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The Clinical Doctor-Patient Interview is the Most Important Diagnostic Tool for an Accurate Diagnosis in General Medicine

Jose Luis Turabian

Specialist in Family and Community Medicine, Independent Researcher/Retired, Formerly of the Health Center Santa Maria de Benquerencia, Regional Health Service of Castilla la Mancha (SESCAM), Toledo, Spain

***Corresponding author**
Jose Luis Turabian, Specialist in Family and Community Medicine, Independent Researcher/Retired, Formerly of the Health Center Santa Maria de Benquerencia, Regional Health Service of Castilla la Mancha (SESCAM), Toledo, Spain.

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The anamnesis, or clinical interview, is the first and most important diagnostic tool during a medical consultation, and is therefore fundamental for an accurate diagnosis. However, in clinical practice, time constraints often shorten consultations. The consequences can be significant: important clinical information may be overlooked, diagnostic errors may occur, and subsequently, avoidable therapeutic errors may result. Furthermore, there are nuances that differentiate the anamnesis in general medicine from that of other specialties, and these are not always mentioned in textbooks.

The interview is a technique, channel, and space for communication, where the doctor-patient relationship is established and developed. The interview integrates communication and clinical reasoning; it connects the biomedical and psychosocial aspects of clinical care. The doctor-patient relationship is fundamental for both diagnosis and treatment [1-3]. In 75-80% of patients, the interview provides the diagnosis (in the remaining cases, examination and additional tests are needed, but even here the diagnosis is more complete when a good clinical interview has been conducted) [4-8].
The sociocultural history accompanies the biomedical history. To understand the illness and the person with the illness, we need to listen to both voices: the real reasons for the visit, and also the beliefs about the illness (both are equally important regarding the effects of the illness on the patient's life) [9].

A good interview fosters a good doctor-patient relationship. The importance of the doctor-patient relationship is evidenced by its proven influence on healthcare outcomes. A "good" doctor-patient relationship is a process where an "alliance" is created: a process in which the doctor adapts to the patient's pace; that is, detecting "what dance the patient is dancing" [10-12].

- The clinical interview typical of general medicine has the following general characteristics: 1. Unstructured and free at the beginning
- Strategic
- Based on strengths from our style and the patient's
- Taking advantage of opportunities
- Contextualized
- Focusing on the "energetic"—significant—elements/topics
- Entering through emotions
- Pragmatic
- Spiraling
- From a life-oriented perspective
- Understanding that our patients are as sick as they are healthy, and that I could be them
- Achieving a situation of interconnection
- Understanding the other is understanding ourselves, and perhaps changing both the other and ourselves
- Empowering interview
- Realistic.

The quality of the clinical doctor-patient interview can be improved by systematically incorporating some simple tactics that require little additional time and, at the same time, enhance diagnostic accuracy.

Tactic 1: Listen Actively and Let Patients Finish Speaking
Doctors often interrupt patients at the beginning of a consultation. Studies show that this occurs, on average, after about 11 seconds. However, most patients need at least than 30 seconds to explain their concerns if allowed to speak without interruption. When patients are interrupted too soon, important symptoms, details about the biopsychosocial context, and the sequence of events may not be fully mentioned, making diagnosis more difficult. List and clarify: adopt an active listening attitude and try to remain impartial while they speak. Then repeat what you have heard to ensure you have understood the message. Constantly ask yourself, "What is this person trying to say with their words, facial expression, posture, the topic they have chosen to discuss, what they are not saying...?" Listening involves hearing, understanding, and empathizing. This strengthens the doctor-patient relationship, and can improve patient satisfaction and the course of treatment [13-14].

Tactic 2: Use Structured Questions
After the initial open conversation about symptoms, the structure of the rest of the dialogue becomes crucial. Structured questions tailored to specific symptoms can help clinicians gather systematic

information. Instead of letting the patient speak freely (open interview), the clinician takes control with a specific script to determine the severity, duration, and exact characteristics of a symptom. Under time pressure, a systematic approach can help prevent overlooking important details or arriving at a provisional diagnosis [15, 16].

Tactic 3: Ask About or be Alert for Warning Signs

Selective detection of warning signs is another essential part of the medical history taking. These warning signs can indicate serious underlying conditions and should always be evaluated, as patients do not always mention them spontaneously. Common biomedical warning signs include unintentional weight loss, night sweats, unexplained pain, neurological deficits, and persistent fever. Biopsychosocial warning signs (key points useful as indicators of potential problems within the patient's context) include: frequent visits for minor problems; frequent visits with the same symptom or multiple visits; visits for symptoms that have been present for a long time previously; visits for a chronic illness that does not appear to have changed; incongruity between the patient's distress and the comparatively minor nature of the symptoms; failure to recover within the expected timeframe after an illness, accident, or surgical intervention; frequent visits by parents with a child with minor problems (the child representing the parents' illness); an adult patient with an accompanying family member; difficulty in making sense of the reason for the visit; consultation of an adult with companion(s); patients with multiple adverse drug reactions (present a higher prevalence of emotional disturbances); appearance of additional demands ("By the way") [17-21].

Tactic 4. Draw or Update The Genogram

The genogram is an instrument or tool of the biopsychosocial model that provides information about the patient, their family, and their context, which implies diagnostic, therapeutic, and prognostic value for the consultation. Creating the genogram fosters a therapeutic bond with the family, leading to a qualitative shift in the relationship. The genogram generates hypotheses—in a circular fashion—about the patient's risk of developing illnesses or experiencing family-related stressors, such as diabetes, hypertension, coronary heart disease, substance abuse, and depression. It allows for the development of a provisional explanation of how the family system is organized around a problem. The genogram reveals family life events, transitions, and turning points, representing opportunities for timely prevention and treatment. "Complex" genograms present families with psychosocial problems that may manifest as biomedical issues. The genogram can be used as a screening tool for all patients, at first glance, regardless of the reason for the consultation, to identify biological or psychosocial problems that could manifest later [22-24].

Tactic 5: Maintain Patient Attention Despite Technology

Digitalization has significantly transformed the history-taking process. Electronic health records, writing during consultations, and constant attention to computer screens can interfere with the doctor-patient interaction. Several studies suggest that multitasking and frequent interruptions can reduce the quality of care. More importantly, eye contact and nonverbal communication can negatively affect conversations with the patient. A practical tactic is to limit note-taking during the consultation and complete detailed documentation later. Standardized templates, voice recognition systems, and AI tools can also help reduce the documentation workload and improve workflow efficiency [14].

Tactic 6: Conclude with a Summary

At the end of the medical history, physicians should briefly summarize the key points discussed. This gives patients the opportunity to clarify, correct, or add information. It improves the accuracy of the information gathered, reduces misunderstandings, and helps patients feel heard and understood. Furthermore, it provides a solid foundation for future diagnostic and treatment decisions [14].

Tactic 7: The Physician-Patient Interview is Compiled and Recorded in the Medical Record

Some characteristics in general practice are: 1) the consultation should be prepared before the patient's arrival, memorizing their background, in order to dedicate full attention to them and mentally integrate their communication with their previous medical history; 2) it may seem that only one person—the patient—comes to the consultation, but this is only superficial: their family or companions and other relevant parties also come in "virtually"; thus, the individual medical history should always be contextualized; 3) the "main problems" or health problems that concentrate the greatest importance, power or significance must be recognized and recorded; 4) it must be remembered that the medical history is built and rebuilt like a sculptor sculpts a sculpture (continuity of care); and 5) at the end of the consultation, certain safety elements must be noted, such as: what will I do if the patient returns for the same problem? [25-26].

In short, effective communication is an essential component of high-quality healthcare. Even in busy clinical settings with limited time, consciously striving to improve history taking can help clinicians make more accurate diagnostic decisions, thereby benefiting patients. In the doctor-patient interview, the doctor-patient relationship is produced and developed, and both are essential for both diagnosis and treatment. In 80% of patients, the interview gives the diagnosis. A good interview promotes a good doctor-patient relationship that has a proven influence on health care outcomes. The quality of the doctor-patient clinical interview can be improved by systematically incorporating some simple tactics that require little additional time while enhancing diagnostic accuracy: Tactic 1: Listen actively and let patients finish speaking; Tactic 2: Use structured questions; Tactic 3: Ask or watch for red flags; Tactic 4. Draw or update the genogram; Tactic 5: Maintain patient attention despite technology; Tactic 6: End with a summary; and Tactic 7: The doctor-patient interview is collected and recorded in the medical record.

References

1. Turabian JL, Perez Franco B (2008) The Effect of Seeing the Sea for the First Time. An Attempt at Defining the Family Medicine Law: The Interview is Clinical Medicine. Aten Primaria 40: 565-566.
2. Turabian JL (2019) Differential Characteristics in Communication and Relationship of the General Practitioner with the Elderly Patient. J Fam Med Forecast 2: 1017.
3. Turabian JL Perez Franco B (2001) Community Activities in Family Medicine and Primary Care. Madrid: Díazde Santos. https://editdiazdesantos.com/wwwdat/pdf/9788479784744.pdf.
4. Hampton JR Harrison MJ, Mitchell JR, Prichard JS, Seymour C (1975) Relative contributions of history-taking, physical examination, and laboratory investigation to diagnosis and management of medical outpatients. BMJ 5969: 486-489.
5. Cooke G (2012) A is for aphorism - is it true that 'a careful history will lead to the diagnosis 80% of the time'? Aust Fam Physician 41: 534.
6. Salisbury H (2026) The use and misuse of fit notes. BMJ 392: 501.

7. Shah R, Clarke R, Ahluwalia S, Launer J (2022) Finding meaning in the consultation: supporting the hermeneutic window in practice. Br J Gen Pract 72: 83-84.
8. Larsen JH, Risør O, Putnam S (1997) P-R-A-C-T-I-C-A-L: a step-by-step model for conducting the consultation in general practice. Fam Pract 22: 295-301.
9. Turabian JL (2019) Interpretation of the Reasons for Consultation: Manifest and Latent Content. the Initiation of the Diagnostic Process in General Medicine. Archives of Community and Family Medicine 2.
10. Turabian JL (2019) Doctor-Patient Relationships: A Puzzle of Fragmented Knowledge. J Family Med Prim Care Open Access 3: 128.
11. Turabian JL (2018) The enormous potential of the doctor-patient relationship. Trends Gen Pract 1. https://www.oatext.com/pdf/TGP-1-115.pdf
12. Turabian JL (2018) Doctor-Patient Relationship as Dancing a Dance. Journal of Family Medicine 11-16.
13. Tennant K, Long A, Toney-Butler TJ (2026) Active Listening. Updated 2023 sep13. In: StatPearls [Internet] Treasure Island (FL): StatPearls https://www.ncbi.nlm.nih.gov/books/NBK442015/.
14. Michael van den Heuvel (2026) Doctors: 5 History-Taking Tips That May Improve Diagnosis. Medscape. https://www.medscape.com/viewarticle/doctors-5-history-taking-tips-may-improve-diagnosis 2026a1000eol?ecd=wnl_tp10_daily_260507_MSCPEDIT_etid8323977&uac=327178AR&impID=8323977.
15. Malterud K, Reventlow S, Guassora AD (2019) Diagnostic knowing in general practice: interpretative action and reflexivity. Scand J Prim Health Care 37393-401.
16. Frank C, (2006) Evidence based checklists for objective structured clinical examinations. BMJ 333546-8.
17. Turabián JL, Pérez Franco B (2008) [Individualized medical care with a community focus. Contextualized care: the figure is the background]. Revista clínica electrónica en atención primaria 16: 1-5.
18. Gutiérrez-Islas, Báez-Montiel BB, Turabian JL (2012) [Patients with adverse drug reactions have a higher prevalence of emotional disorders]. Aten Primaria 44: 720-726.
19. Turabián JL, Pérez Franco B (2015) [The companion in the primary care clinical interview]. Semergen 41206-41213.
20. Turabian JL (2015) [Models of care centered on the patient's companion. The family and the context: on the edge of the doctor-patient relationship in family medicine]. Saarbrüc] ken, Deutschland/Germany: Editorial Académica Española https://www.amazon.es/Modelos-atenci%C3%B3n-centrada-acompa%C3%B1ante-paciente/dp/3659097756
21. Turabian JL (2017) "ByThe Way…" Phenomenon: A Qualitative Study of the Additional Demands in Closing Moments of Medical Interview in Family Medicine. J Gen Pract 5: 342.
22. Jose L (2017) Turabian. Family Genogram in General Medicine: A Soft Technology that can be Strong. An Update. Res Med Eng Sci 3. http://crimsonpublishers.com/rmes/pdf/RMES.000551.pdf
23. Turabian JL (2023) A Biopsychosocial Instrument to Study and Intervene in the Complexity of Changes and Stability of Family and Community System Health: The Genogram. Arch Health Sci 71-78.
24. Turabian JL (2025) Storytelling, biography, and genograms. BMJ 390: 1771.
25. Turabian JL (2018) Twelve Commandments for General Medicine Clinical Record: Some Suggestions That Are Not InThe Text books. Archives of Community and Family Medicine 121-29.
26. Turabian JL (2026) The Iceberg Principle in the General Practitioner's Medical Record: Narrative, Biography, Genogram and Context. Clinical Medical Reviews and Reports 8.