A physician once saved my life with a question, or more precisely, with two questions.

I had been short of breath for several months. Because I had had some cardiac problems in the past—an episode of pericarditis seven years previously—I called my cardiologist. He thought it sounded like a slight worsening of my generally mild asthma, and reassured me. As the weeks passed, I had good days and bad days, and sometimes I worried more and sometimes less. At some point I organized a chest X-ray and an ECG for myself, and I also saw my GP. The tests were normal, there were no physical signs of anything, and the message was one of unconcerned uncertainty.

Then one day I could not walk to the shops at the end of the road without stopping. My wife thought that my lips were now slightly blue. She insisted that my GP should send me to hospital. In the back of my mind I had a nagging fear that I was having pulmonary emboli. In any logical sense, this seemed absurd. I had no pain in my chest or legs, no cough and no haemoptysis. I was generally fit, and had not gone on any long flights that year. But my mother had died of a pulmonary embolus during a hospital admission. Also, for the first time in my life, I was unaccountably having dreams about her brother, who was murdered by the Nazis as a teenager—almost certainly by cyanide asphyxiation in Auschwitz. I had not known him, and she had virtually never talked about him.

I saw a consultant chest physician who could not have been more thorough, but it was clear from her questions that pulmonary emboli did not figure remotely in her thinking. All the same, when she had finished examining me, she asked: ‘Have you come up with any diagnosis yourself?’ Sheepishly, and with the slight fear of ridicule that comes with not being a specialist, I told her of my specific anxiety. She then asked one further question: ‘Does that mean you’d like a V/Q scan to reassure you?’ I said yes. Three days later it was done, and showed I had already lost 25% of my lungs to multiple infarcts. ‘You’re a very good diagnostician’ she said, graciously. I never told her about the bad dreams.

At medical school, we are taught meticulously about the importance of asking the right questions. Yet in our subsequent careers we often forget two of the most crucial ones: ‘What do you think you’ve got?’ and ‘How can I persuade you otherwise?’ As my physician demonstrated, the art of questioning clearly needs to go beyond the dry litany of formal history-taking and should embrace the patient’s view as well. When we remember this, we nearly always save our patients many sleepless nights, and sometimes we save their lives too. (Even patients who are not medics can have improbable but correct intuitions about what is wrong with them.)

The art of questioning may go further still. One of the most challenging researchers ever to have looked at questions in clinical consultations is the Canadian psychologist Karl Tomm. He talks of conversations between professionals and patients as being treatments in themselves. He doesn’t mean this the relatively banal sense of offering reassurance or empathy. Instead he talks about ‘questions as interventions’ and of consultations as ‘interventive interviewing’. He suggests that the chief purpose of clinical questioning is not primarily to pin problems down, but to try and redefine and resolve them through the conversational process itself. Although Tomm is writing principally about consultations in mental health settings, his approach to questioning may have equal, if not greater, application to medical contexts.

As a result of his researches, Tomm has proposed ways of using questions in order to call forth new and unexpected expressions, memories and ideas from the patient—including ones that they might otherwise not have expressed, or even thought. He makes a distinction between four principal types of questions. ‘Lineal’ questions are straightforward ones about facts and causes, the kind that doctors are asking all the time (‘how much alcohol do you drink?’). ‘Circular’ questions invite people to think...
about themselves not as mere passive objects but as participants in a dynamic dance of human interactions (‘who gets most upset about your level of drinking?’). ‘Strategic’ questions implicitly propose options for changing the situation (‘what help would you need if you tried to cut down on your drinking?’). ‘Reflexive’ questions jolt patients into new ways of looking at their predicaments by examining them in an unexpected light (‘if you succeeded in giving up, are there other more difficult problems you might have to face?’). Tomm counsels moving between these four types of questions, so that consultations are challenging without being confrontational, and never fall back into ritual or repetitiveness. One way of describing the kind of clinical interview that he teaches is as ‘consultations inviting change’.

Tomm’s original paper on questions has a stupefyingly off-putting title and it appears in a journal that few doctors will have heard of (Tomm K. Interventive interviewing: part III. Intending to ask lineal, circular, strategic or reflexive questions? *Family Process* 1988; **27**:1–15). Nevertheless, I would say that it has influenced my professional behaviour more than anything I have ever read—and almost as much as the two questions that my chest physician asked.

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