Comprehensive, research-based interviewing guidelines in general practice settings

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Medical interviewing has evolved considerably during the last 35-50 years. Nowhere has progress been greater than with the articulation of the interview's endpoint, the biopsychosocial model (Engel, 1977b; 1980). Interviewers collect personal information and physical symptoms from the patient and, then, synthesize these data to produce a biopsychosocial description — the patient's story. We generally recognize the systems-based biopsychosocial model as the gold standard for understanding the patient from a scientific as well as humanistic vantage point (Simpson, 1963; von Bertalanffy, 1968; Lorenz, 1971; Brody, 1973; Weiss, 1973; Bateson, 1979; Mayr, 1982). Extensive research supports this position.

THE BIOPSYCHOSOCIAL MODEL IS ONLY AS GOOD AS THE PATIENT-CENTERED METHOD USED TO OPERATIONALIZE IT

The biopsychosocial model has not helped as much as once hoped in fostering a humanistic, patient-centered medicine — where patient-centered interviewing practices must be implemented to identify relevant personal and symptom data and to establish an effective provider-patient relationship. The model simply tells us what information we need about the patient without telling us how to acquire it (Smith, 1996; 1997). At this time, we understand the biopsychosocial model far better than the patient-centered interviewing process needed to operationalize it.

Troublesome in this respect is that many view patient-centered interviewing as time-consuming and difficult to learn, greatly impeding acceptance and implementation. To be certain, mastery of interviewing requires more than the intellectual understanding that suffices with the biopsychosocial model. Experiential learning about usually unfamiliar skills must occur but, as we have shown (Smith et al., 1998), this is not an insurmountable task.

Because patient-centered interviewing has progressed more slowly, the original promise of the biopsychosocial model has not been met. In my opinion, this failure occurred, not for a fault in the model but for failure to develop user-friendly and comprehensive patient-centered methods to effectively and efficiently operationalize it. To the extent patient-centered methods are ineffective, the biopsychosocial model remains only a theoretical construct of little practical importance in caring for individual patients on a daily basis. The solution is not to devise new models but, rather, to improve our patient-centered method.

PATIENT-CENTERED INTERVIEWING CAN TRANSFORM MAINSTREAM MEDICINE AND VICE VERSA

Many recent advances have improved the patient-centered method considerably and include identification of: a curriculum (Lipkin et al., 1984; Kem et al., 1989; Roter et al., 1990; Smith et al., 1991; 1998; Langewitz et al., 1998), a structure of the interview (Lipkin, 1987), the three functions of the interview (Bird & Cohen-Cole, 1991; Cohen-Cole, 1991; Lazare et al., 1995), the actual process of the interview (Rogers, 1951; Lazare et al., 1975; Lipp, 1977; McWhinney, 1981; 1989; Levenstein et al., 1986; 1989; Lipkin, 1987; Smith & Hoppe, 1991; Smith, 1996), critical features of the doctor-patient relationship (Engel, 1977a; Relser & Schroder, 1980; Brody, 1982; Freeling, 1983; Quill, 1983; 1989; Cassel, 1985;}

Epidemiologia e Psichiatria Sociale, 8, 2, 1999
Lazare et al., 1987; Novack, 1987; Roter et al., 1987; Hall et al., 1988; Suchman & Matthews, 1988; Kaplan et al., 1989; Smith, 1996), and the impact of physician self-awareness on the interview (Johnson, 1979; Gorlin & Zucker, 1983; Smith, 1984; 1986; 1995; Smith & Zinnny, 1988). Central to this success has been research that anchored interviewing to what actually is effective (Rogers, 1951; Korsch et al., 1968; Freemont et al., 1971; Ley et al., 1976; Kleinman et al., 1978; Carroll & Monroe, 1979; Cox et al., 1981a, b; 1988; Hopkinson et al., 1981; Carter et al., 1982; Burack & Carpenter, 1983; Beckman & Frankel, 1984; Frankel, 1984; Mishler, 1984; Stewart, 1984; Putnam et al., 1985; 1988; Maguire et al., 1986; Francis et al., 1987; Kleinman, 1987; Roter et al., 1987; Hall et al., 1988; Roter, 1989; Smith et al., 1995a, b; 1998; Langewitz et al., 1998). In teaching interviewing to students, housestaff, faculty, practitioners, nurse practitioners, and physician assistants during the last 20 years, I have observed remarkable improvement in developing a relationship and obtaining the patient’s personal story, a refreshing contrast to the old isolated focus on organic disease.

Unhappily, in spite of progress in patient-centered medicine, the «old school» favoring an isolated doctor-centered interview aimed at making just a disease diagnosis still holds sway, continuing to bind modem medicine to the biomedical (biotechnical) model which pays little attention to the personhood of the patient. Indeed, many medical schools still attend poorly to training in interviewing (Novack et al., 1993), many interviewing texts neither reference «patient-centered» nor evince its practice in their recommendations, and many residencies don’t effectively broach the topic (Merkel et al., 1990; Parrino & Kern, 1994; Sullivan et al., 1996) — all of which encourage and reinforce an isolated doctor-centered interviewing approach. And all this in light of the well documented benefits from integrating patient-centered and doctor-centered interviewing methods. For example, it has been shown through rigorous research that using a patient-centered method improves patient satisfaction and compliance (Roter et al., 1987; Hall et al., 1988), and health outcomes (Egbert et al., 1964; Shear et al., 1983; Kaplan et al., 1989). Nor does anyone dispute that patient-centered medicine is more humane for the doctor as well as for the patient (Roter et al., 1987; Hall et al., 1988; Suchman & Matthews, 1988). Or that doctor-shopping and litigation are reduced (Kasteler et al., 1976; Huycke & Huycke, 1994).

Why is it, then, that biomedicine and its educators have not fully embraced a patient-centered interviewing approach? We make a mistake, in my opinion, to blame this impasse on psychological resistance, which we sometimes hear as an explanation. After all, mainstream medicine has quite avidly accepted the well known and frequently taught biopsychosocial model. Instead, I propose that we take more seriously the legitimate educational and scientific requirements of our mainstream colleagues. To ignore them will not only diminish the quality of our own products, but almost certainly will continue to interfere with acceptance of our patient-centered principles by mainstream medicine.

To cite two specific examples, until recently, there had been no publication of a complete, step-by-step method for patient-centered interviewing, perhaps the most complex task in all clinical medicine. This ignores the recommendations of many mainstream as well as patient-centered educators for developing detailed, behaviorally-defined methods/models for teaching complex topics of any sort (Carroll & Monroe, 1980; Flaherty, 1985; Schunk, 1985; Stewart & Roter, 1989; McKeachie et al., 1990; Maguire, 1992; Feinstein, 1994; Westberg & Jason, 1994; Kurtz & Silverman, 1996). Secondly, interviewing recommendations in texts and elsewhere have had little or no data to support them, again ignoring a central tenet of modern, evidence-based medicine (Sackett et al., 1997). Understood this way, when we recommend and use nonsystematic, nonresearch-based interviewing methods, we inadvertently flaunt the valuable principles of the very biomedical and educational people we need to convince.

BEGINNING EFFORTS TO ADDRESS THE PROBLEM

In grappling with this problem, our group was fortunate in two respects. First, a rich patient-centered literature existed. What remained to be done was to put all the pieces together into one step-by-step, complete method — a daunting task which, likely, no one previously had had sufficient time and funding to do. Second, we encountered the Fetzer Institute (Kalamazoo, MI). Fetzer provided the funding and moral support that allowed us to proceed with a previously impossible task: 1) synthesizing a detailed, behaviorally-defined patient-centered interviewing method that described, step-by-step, how one proceeded throughout the entire interview

Epidemiologia e Psichiatria Sociale, 8, 2, 1999

86
and 2) testing the method rigorously in a randomized controlled trial. We were indeed privileged to be able to identify a comprehensive and detailed patient-centered interviewing method (Smith, 1996), one not unlike what we suspect others would have identified given the unique opportunity. In turn, we showed that the method was effective (Smith et al., 1995a, b; 1998).

The method. The new, detailed patient-centered interviewing method consists of steps 1-5, with some 25 substeps, which immediately precede steps 6-12, the standard doctor-centered interview. Each substep is behaviorally-defined, the behaviors are ordered and sequenced, and priorities within the interview are identified. The patient-centered interviewing method is learned easily. Most students and physicians can effectively conduct the steps and substeps after two teaching sessions. Although taking longer while learning it, the five steps can be completed with most patients in no more than 3-5 minutes by the completion of training, meeting our objectives that the patient-centered interview must be efficient.

There is one caveat. This method is more detailed and specific than earlier forms of patient-centered communication. Learners have to work harder to learn this more detailed material, especially at the outset when they learn the 5 steps and 25 substeps. They have not complained or resisted and, rather, have been excited and pleased with their results. Teachers also indicate that the method is «more substantive,» and that this is corroborated by their students who previously complained that interviewing training was «just boring repetition of the same old stuff;» these students report now that training is «tangible» rather than diffuse. Learners who have had previous interviewing training comment that they have understood for the first time how the many skills fit together, that they value the efficiency, and that they have more confidence.

Concerns about detailed methods. Some teachers who had not used the 5-step method were understandably concerned that any specific method could destroy the individuality of patient and interviewer alike, that the uniqueness of the patient and interviewer would be lost in a slavish repetition of a specified series of questions (Gruen, 1986). In my experience with patient-centered interviewer teachers, this anxiety has been the major impediment to developing and implementing comprehensive, detailed interviewing methods. While providing explicit guidelines and signposts throughout the interview, the 5-step method remains quite flexible and does not prescribe specific questions or rigid routines. Those teachers using the method report that it fosters both the interviewer's and the patient's individuality greatly enhancing the humanistic dimension for each, as our research also showed (Smith et al., 1995a, b, 1998). Rather than a rote procedure, the method simply brings a discipline and complete guidelines for how one proceeds throughout the interview, not unlike physicians' use of guidelines when first learning to perform the physical examination. The educational literature reports similarly that explicit behaviorally-defined methods and models for complex tasks not only allow learners to be more effective and confident but also more uniquely themselves when faced with complex, otherwise nearly insurmountable tasks (Carroll & Monroe, 1980; Flaherty, 1985; Schunk, 1985; Stewart & Roter, 1989; McKeachie et al., 1990; Maguire, 1992; Feinstein, 1994; Westberg & Jason, 1994; Kurtz & Silverman, 1996).

The research. The randomized controlled evaluation, in brief, showed that experiential training with this 5-step patient-centered interviewing method produced striking improvement in first year residents' knowledge, attitudes, and skills concerning patient-centered interviewing (Smith et al., 1995a, b; 1998). We also found a consistent trend towards improvement in the patients of trained residents: increased satisfaction and decreases in somatic complaints and social dysfunction. The key change in residents' attitudes was an increase in self-efficacy, or self-confidence, in using patient-centered interviewing skills. Bandura and others have shown that self-efficacy is a key predictor of actual performance of skills being taught (Bandura, 1977; 1986; Schunk 1985; McKeachie et al., 1990; Tresolini & Stritter, 1992). In addition, we demonstrated very significant changes on all eleven scales we used to evaluate patient-centered interviewing skills, the evaluations deriving from real patients as well as simulated patients. We concluded that trained residents, compared to control residents, exhibited much better relationships and patient-centered interviewing skills and that the trained residents were effectively and efficiently replicating the new, 5-step patient-centered interviewing method we had taught them. Our experience with medical students, graduate physicians, nurse practitioners, and physician assistants reveals that discipline and level of training have no impact on ability to learn and use the 5-step interviewing method, and that the method is applicable.
for all new learners; we studied first year residents because that was the focus of funding.

SCIENCE AND THE PATIENT

To put systematic, comprehensive, and research-based patient-centered interviewing (of the type described here or other types) into broader context, recall Feinstein's and others' laments: modern medicine has no scientific identity, has no intellectual base, and is nothing more than a potpourri of material imported from other disciplines such as, for example, each basic science, epidemiology, biostatistics, sociology, economics, and anthropology (Feinstein, 1987). This troubles many because none of these disciplines has the personal dimension of the medically ill patient as a focus. In fact, few deal at all with patients! We thus have the paradox that medicine, where the patient is paramount, has come to stand on a nonclinical base (Feinstein, 1987). Of course, no one advocates scrapping these dimensions which have contributed so much to the successes of modern medicine. Rather, the plea is to bring the patient back into medicine, as the hub of medicine with spokes radiating out to each component discipline. Not surprisingly, a nonclinical base has prevented medicine from most meaningfully addressing the personal issues of greatest interest to the patient: treatment, prognosis, and other decisions in patient care (Feinstein, 1983a; 1987, 1994; Cassidy, 1994).

Engel, Feinstein, and McWhinney, among many, have challenged clinicians to better define the science of medicine around the personhood of the patient if medicine is to progress as a science. To do this, we are encouraged to develop better methods and better models (Engel, 1977a, b; 1987; McWhinney, 1981; 1989; Feinstein, 1983a, b, e, d, 1987).

A patient-centered interviewing method that is behaviorally-defined, describes a complete interview, and is detailed can extend and refine the more general patient-centered methods previously espoused by educators, humanists, and scholars (Rogers, 1951; Lazare et al., 1975; Lipp, 1977; McWhinney, 1981; 1989; Levenstein et al., 1986; 1989). As students, physicians, nurse practitioners, and physician assistants use a method that is more complete and specific, they will obtain more data uniquely reflecting the individual patient and form better relationships. This, in turn, allows them to synthesize a more accurate biopsychosocial description of the patient with respect to biomedical (disease) as well as psychosocial data; i.e., disease diagnosis and management and humanistic practices will be enhanced. The improved method thus better «operationalizes» the biopsychosocial model and makes it more applicable and practical on a daily basis with individual patients. As the biopsychosocial model becomes more specific to the individual patient, it becomes more credible in establishing a base for medicine in general system theory (Simpson, 1963; von Bertalanffy, 1968; Lorenz, 1971; Brody, 1973; Weiss, 1973; Bates, 1979; Mayr, 1982). Put another way, a systematic, complete patient-centered interviewing method helps us toward a key objective (Foss & Rothenberg, 1987): that we find a strategy that «treats the individual patient in the context of his or her mutually interacting 'biocultural' identity.»

For these improvements in our guiding patient-centered method and biopsychosocial model to have maximum impact, however, we are advised that they must also have a strong research base if patient-centered interviewing is to become truly scientific (Inui & Carter, 1985). That is, if we are to evolve as a scientific discipline, good ideas will be viewed as hypotheses requiring empirical support. Rigorously applying an experimental approach to proposed comprehensive methods will make our discipline more scientific as well as more humanistic.

CONCLUSION

As we develop systematic, comprehensive, and research-based methods in patient-centered communication, we will not only improve the scientific and humanistic quality of our product, but we also will have a better chance to overcome current objections to our integration into mainstream medicine. If this exciting prospect for the future occurs, all of medicine could someday be characterized by a transformed clinical method (McWhinney, 1989). The patient-centered interviewing method discussed here is simply an example of this direction and but one very small step in making the requisite paradigm shift (Kuhn, 1962).

REFERENCES


Epidemiologia e Psichiatria Sociale, 8, 2, 1999
Comprehensive, research-based interviewing guidelines in general practice settings


Epidemiologia e Psichiatria Sociale, 8, 2, 1999 89
Comprehensive, research-based interviewing guidelines in general practice settings


