PATIENT-CENTERED INTERVIEWING CURRICULUM FOR RESIDENTS

Brief – 24 Hours Contact
CURRICULUM FOR RESIDENTS

Robert C. Smith, MD
Professor, MSU College of Human Medicine
355-6516
Email: smithrr@pilot.msu.edu

Catherine E. Lein, RN, MS, CS
Instructor, MSU College of Nursing
355-1848
Email: leink@pilot.msu.edu
CURRICULUM FOR RESIDENTS

Course Description:

This course focuses on the patient centered communication and interpersonal skills needed by residents in a primary care setting. The course emphasizes the biopsychosocial dimensions of medicine with a focus on underserved populations. The impact of cultural diversity and personality styles will be discussed.


Course Objectives: The resident will be able to:

1. Analyze and demonstrate communication skills needed for professional interaction with patients (as found in text, chapter 2, table 2)
2. Integrate appropriate interviewing responses to facilitate effective physician-patient communication (chapter 3, steps 1-5)
3. Discuss the influence diversity may have in the physician-patient relationship, specifically patients in Medicaid populations
4. Critique and evaluate interviewer responses, including on-going self critique/evaluation
5. Identify challenging patient situations that may occur during an interview (outlined in chapter 6)
6. Evaluate the interviewer's own personal impact on the patient and the patient's impact on the physician (chapter 7)

Instructional Model:

The course includes 24 hours of direct contact utilizing didactic, role playing and class discussion materials. The training is designed for 3-4 residents and may need to be taught 3-4 times per year. Subsequently, to enhance retention of skills, residents will spend 2 hours per month with faculty to review video/audio tapes and will write self assessments related to interviewing techniques. (The total number of hours per rotation would need to be increased if the group of learners is greater than four.)
Resident Training Course Schedule: *see following page for diagram*

Deployment is scheduled for March 2000 and may need to be repeated 3-4 times per year

A. Teaching: Total of 24 hours

  Week 1:  
  4 hours on Monday (Session 1)  
  4 hours on Thursday (Session 2)  
  Weeks 2-9: 2 hours each Thursday (Sessions 3-10)

B. Practice: total of 24 hours

  Sessions 1-2: 4 hours between sessions (total of 8 hours)  
  Sessions 3-10: 2 hours between sessions (total of 16 hours)

C. Longitudinal Reinforcement: 2 hours per month throughout the remainder of the residency will be arranged with faculty to review video/audio tapes of interviewing experiences

*Total course time is 48 hours per resident: 24 hours teaching content and 24 hours practice*
RESIDENT TRAINING - March 2000 (total 48 hours)

Week 1

Teaching (24hrs):
- Session 1
- Session 2
- Session 3 - 10

Practice (24hrs):
- 2 four hour practice sessions (8 hours)

Weeks 2-9

- 2 hours each Thursday
- 2 hours each week (16 hours)

Rest of Residency
(Review video/audio tapes of interviewing experiences)

Longitudinal Reinforcement
- 2 hours per month
INTRODUCTION:

Teaching interviewing can be a demanding undertaking and considerable skills are required to be effective. However, most physicians are very aware of the importance of patient interviewing, so the topic is one that already holds a priority in their practices.

Presenting a model, such as Integrated Patient-Doctor Interviewing, is a particularly effective teaching tool. Although teaching interviewing requires a rather structured approach, teachers need to maintain a balance of learner-directedness within the confines of this structure. To do this, it is important to establish an atmosphere and opportunity for learners to:

1) Identify course goals as their own (e.g., patient-centeredness, self-awareness)
2) Identify their own interviewing and self-awareness problems and devise learning goals and teaching techniques to address them (e.g., role play)
3) Lead discussions and provide feedback to each other, taking responsibility for some teaching as well as learning
4) Assist in directing their own learning (e.g., controlling the tape recorder during critiques)
5) Determine the direction they want to take personally and professionally by developing self-awareness. Learner-directedness actively involves learners and enhances learning and self-efficacy.

Teaching an integrated interviewing process to residents, as presented in chapters 1-5 of the text, is fairly straightforward and outlined here. In essence, the teacher presents the facilitating skills, then focuses repeatedly on the first five steps of the interviewing model, and finally integrates the doctor-centered steps of the model. A video tape which accompanies the text will reinforce this approach. Virtually all students and residents are able to learn these skills quickly to produce a coherent interview.

Ordinarily, residents have a good grasp of basic patient-centered skills after 1-2 weeks and the work focuses more and more on how to use newly acquired psychosocial information in clinical circumstances and on continued personal self-awareness. However, this rotation needs to be learner-centered just as the learning material presented is patient-centered. Instructors will need to assess the learners' responses and adjust the pace accordingly.

The following is an outline of the proposed 24 contact hour teaching block for residents. Assignments between sessions require approximately 2 hours.
SESSION 1: The first session includes two components (4 Hours)

1. Integrated interviewing and the biopsychosocial story
2. Questioning and relationship-building skills

Required Reading: Chapters 1-2 should be assigned beforehand so that learners are prepared to discuss the content

Part 1: Integrated Interviewing

Objectives: The learner should be able to discuss and demonstrate the described interviewing skills

A. Interviewing is important
   1. What are human data, and why is this definition important?
   2. Define interviewing
   3. Why is interviewing the most central of all clinical skills?

B. An Integrated interview permits the learner to synthesize the biopsychosocial story
   1. Define medicine’s models
      a. Biopsychosocial model
      b. Biomedical model
      c. Why is the biopsychosocial model superior to the biomedical model?
   2. Define different interviewing processes
      a. Doctor-centered interviewing
      b. Patient-centered interviewing
      c. Describe how one transforms multiple bits of personal and symptom data to a biopsychosocial description of the patient—the patient’s story
   3. Integrated Patient-Doctor Interviewing
      a. What are the different needs a patient may have?
      b. Why is an integrated approach more humanistic and more scientific?
      c. Describe how one interfaces patient-centered and doctor-centered processes. Which usually comes first? Are they rigidly separated or can one go back and forth between them?
d. Define the three functions of interviewing (data-gathering, relationship-building and patient education) and know which two are concerned in this basic interviewing instruction

**Small Group Work: General Comments**

1. Emphasize the objectives, especially understanding that Integrated Patient-Doctor Interviewing elicits multiple bits of symptoms and personal data that the interviewer, relying on a knowledge base in medicine, synthesizes to make a biopsychosocial description of the patient.

2. Use role play to illustrate different patient needs: the usual uncomplicated patient and more troublesome situations, such as the unconscious or psychotic patient. Emphasize that present instruction will concern only situations in which no urgent problem exists and where patients are able to and want to communicate.

3. Demonstrate an isolated doctor-centered interview to show what is to be avoided. Indicate that doctor-centered interviewing will be integrated later.

4. The teacher concludes this focus by reviewing why an integrated patient-centered and doctor-centered approach is superior to an isolated doctor-centered approach. Learners usually understand the humanistic reasons, but the following three scientific reasons merit repetition throughout the course:

   a. The biopsychosocial model is based in general system theory, a principle embodied in the revolution in modern physics at the turn of this century, and provides a more modern and multidimensional description of the patient than the unidimensional biomedical model.

   b. Research also shows that the data from an integrated approach produce a more comprehensive and more accurate description of the patient. Theoretically, these data also are more consistent and less biased. Thus, the data about the subject of the science of medicine (the patient) are more valid and more reliable.

   c. Finally, research data show the deficiencies of an isolated doctor-centered approach and the superiority of integrating a patient-centered approach, as outlined in the text.
Small Group Work: Detailed Outline (1½ hours)

1. Begin with introductions and learners' reactions to interviewing rotation (15 minutes)
2. Review definitions from objectives (5 minutes)
3. Briefly demonstrate different patient needs in role play, using a learner as the interviewer (15 minutes):
   a. obvious acute problem (unconscious, massive hematemesis, psychotic or symptoms of acute MI)
   b. obvious communication problem (dementia)
   d. no acute problem and no communication problem—vast majority of circumstances and only focus of this course.
4. The group discusses Integrated Patient-Doctor Interviewing and its component processes (15 minutes)
5. Demonstrate learners' initial objective for this teaching block: the complete patient-centered process of HPI with transition into doctor-centered HPI; instructor should review chapter 3 beforehand (20 minutes)
6. Discuss why the doctor needs to be skilled using the patient-centered process and what unique humanistic and scientific benefits accrue—see chapter 1 of the text (20 minutes)

Teacher's Guide

1. One treats the learners the way they will be taught to interact with the patient: respectfully with caring and sensitivity, considering emotion as well as verbal material, using open-ended and closed-ended inquiry, using relationship-building skills, negotiating, giving feedback and setting limits.
2. Teachers attend to group process, encourage but do not force everyone's involvement and allow time for learners to express apprehensions and other emotions about the material.
3. Nonphysician teachers can ask a physician colleague about what constitutes an urgent medical problem, the general doctor-centered approach to such a patient and what is covered in the doctor-centered approach; also see chapter 5 of the text.
Part 2: Questioning and Relationship Building Skills

Objectives: The learner should be able to discuss and demonstrate the following skills

I. Questioning Skills
   A. Open-ended
      1. Silence
      2. Nonverbal encouragement
      3. Neutral utterances, continuers
      4. Reflection, echoing
      5. Open ended requests
      6. Summary, paraphrasing
   B. Close-ended
      1. Yes/no answers
      2. Brief answers

II. Relationship-Building Skills
   A. Emotion-seeking
      1. Direct “How does that make you feel?”
      2. Indirect: self disclosure, impact on life, impact on others, belief about problem
   B. Emotion-Handling
      1. Naming, labeling “So, that made you sad”
      2. Understanding, legitimating “I can understand that”
      3. Respecting, praising “You’ve had a difficult time and handled it well”
      4. Supporting, partnership “Working together, you and I can get to the bottom of this”

Small Group Work: General Comments

1. Discuss and demonstrate open-ended, closed-ended, emotion-seeking, and emotion-handling skills. Highlight that these very simple skills are the key skills in successful patient-centered interviewing. Also remind learners that while these skills are intellectually easy to comprehend, they are difficult to perform because they are counter to much prior learning and experience.
2. Demonstrate how the interviewer can focus the patient using focusing open-ended or relationship-building skills. Emphasize that this may require interrupting the immediate thread of conversation to return to earlier material. Emphasize also that data not introduced by the patient should not be introduced by the learner using open-ended requests or emotion-seeking skills. That is, if 'job' has not been mentioned by the patient, the learner does not say, “Tell me about your job” or “How do you feel about your job?”. Being patient-centered in the interview means no data can originate in the learner’s head.

Small Group Work: Detailed Outline (2 ½ hours)

1. Conduct general discussion and reaffirm self-awareness as an objective, including why this is important (15 minutes)
2. Using role play, learners practice open-ended skills, emotion-seeking skills, and emotion-handling skills. Challenge learners to completely avoid closed-ended questions and predict that this will be difficult. The learner interviewee can role play either a patient or a non-patient; interviewees are instructed to show moderate levels of emotions and not to “make it difficult”. (60 minutes)
3. The instructor then demonstrates the focused use of Facilitating Skills. She/he uses focusing open-ended skills, emotion-seeking skills, and emotion-handling skills on selected patient utterances in two situations: a) to focus on the patient’s immediate thread of conversation or emotion b) interrupting the immediate thread to focus on prior patient utterances or emotion. The intent is to show learners how to open-endedly focus the interview, a skill with which they will need to be proficient. Focusing is the key to developing the narrative thread in an efficient way, while remembering that new material should not be introduced. (30 minutes)
4. Each learner role plays 30 seconds of non-focused open-ended inquiry (using non-focusing open-ended skills: silence, neutral utterances, and nonverbal encouragement) followed by 3 minutes of focused inquiry with focusing open-ended skills, emotion-seeking skills, and emotion-handling skills. Learners are instructed to focus on whatever utterances they desire and follow the thread of whatever story emerges—by repeated focusing with the skills. (45 minutes)
Teacher's Guide:

1. Orient learners that teaching will focus on individual skills in this session and that subsequent sessions will put the skills together into the Integrated Patient-Doctor Interviewing process.

2. Non-focused open-ended skills are easily understood and performed. Most teaching time and emphasis will be on the focusing open-ended skills, emotion-seeking skills and emotion-handling skills.

3. Review role play techniques and anticipate issues that often arise around this; e.g., performance anxiety (in either patient or interviewer role), disdain because “patients” are not “real”, disrupting role play by laughing and otherwise not taking it seriously.

4. Use only one role play at a time. Each non-interviewing learner can be assigned 1-2 specific tasks (e.g., watch for silence, identify when open-ended and closed-ended techniques are used, identify emotion-handling skills) and give feedback to the interviewer—after the instructor initially leads discussion about both participants’ reactions.

5. In role play, give explicit instructions about what the “patient’s” role and script should be; this makes is easier for learners and prevents wasting time; alternatively, the teacher can take the role of the patient, particularly at the outset when anxiety levels are high. Support “patient’s” efforts; they often are overlooked and stressed about their performances.

6. Listen carefully and respond empathically to learners’ anxieties about role play. This is a good opportunity for further encouraging learners' emotions, a prerequisite to effective self-awareness work, and for the instructor to demonstrate her/his own facilitating and negotiating skills.

Learners Assignment for next Session:

1. Read chapter 3

2. Before the next class, interview a non-patient (friend, spouse) with the objective of: remaining entirely open-ended for three minutes, using emotion-seeking skills at least three times, and using emotion-handling skills at least three times. Audio/videotape this interview for review at the next session. Jointly critique it (what objectives were met and not met) with a fellow learner prior to the next session and be prepared to discuss and critique the interview.
SESSION 2: Integrated Patient-Doctor Interviewing: Patient-Centered Process (4 Hours)

Objectives: The learner should be able to discuss and demonstrate:

1) Facilitating and Relationship-Building Skills from Session 1
2) The following 5 step Integrated Patient-Centered Process: all 5 steps and 25 sub-steps

I. Setting the stage for the interview (Step 1)

   A. Welcome the patient
   B. Use the patient’s name
   C. Introduce self and identify specific role
   D. Ensure patient readiness and privacy
   E. Remove barriers to communication
   F. Ensure comfort and put the patient at ease

II. Chief Complaint/Agenda setting (Step 2)

   A. Indicate time available
   B. Indicate own needs; e.g., take history and perform physical examination
   C. Obtain list of all issues patient wants to discuss; e.g., specific symptoms, requests, expectations, understanding
   D. Summarize and finalize the agenda; negotiate specifics if too many agenda items

III. Non-focused Interviewing (Step 3)

   A. Open-ended beginning questions
   B. Non-focused open-ended skills: silence, neutral utterances, nonverbal encouragement
   C. Focused open-ended inquiry also appropriate if needed to get patient talking: echoing, summary, requests
   D. Closed-ended questions for clarification
   E. Obtain additional data from the following sources: nonverbal clues, physical characteristics, autonomc changes, accouterments and environment
IV. Focused Interviewing (Step 4)

A. Obtain personal description of the symptoms (Focusing open-ended skills)
B. Extend the story to the broader, personal context of the symptoms (Focusing open-ended skills)
C. Develop a free flow of personal data (Focusing open-ended skills)
D. Develop an emotional focus (Emotion-seeking skills)
E. Address the emotion/s (Emotion-handling skills)
F. Use the cycle of "core dynamic skills" repeatedly to better identify and deepen the story (focused open-ended skills, emotion-seeking skills, emotion-handling skills)
G. Conclude and address other current issues

V. Transition to the Doctor-Centered Process (Step 5)

A. Brief summary
B. Check accuracy
C. Indicate that both content and style of inquiry will change if the patient is ready

Small Group Work: General Comments

1. Review Questioning and Relationship-Building Skills. Repeat demonstration of how one uses open-ended, emotion-seeking and emotion-handling skills to focus on something the patient has said or expressed emotionally, including interrupting the immediate thread to return the focus to earlier conversation or emotion. Reaffirm that new topics should not be introduced by the learner. The ability to focus on material introduced by the patient will be a major determinant of the learner's effectiveness and efficiency.

2. Review and demonstrate the new objectives in role play: the 5-step method. Emphasize that each step and sub-step is covered in the order noted, at least for initial training purposes. The 5-steps and 25 sub-steps are the initial bottom line for this course and by the end of the course everyone should be able to do what the teacher demonstrates. Reassure learners that once basic skills are established, many variations are possible and encouraged, as outlined in chapter 6 of the text.
3. Emphasize the importance of obtaining the patient's agenda. Reassure learners that it sometimes involves interrupting the patient and that respectfully interrupting can be a valuable patient-centered skill.

Small Group Work: Detailed Outline

1. Teachers review tapes and experiences with interviews that were done since the Session 1 assignment (60 minutes)
   a. Ask about each learner's experiences, always beginning with her/his emotional response. Simply getting learners to share emotions at this point is satisfactory, e.g., anxious being watched. The instructor acknowledges with NURS (naming, understanding, respecting, supporting) and reinforces their recognition and sharing of emotion.
   b. Spend most time on specific skills issues. Teachers highlight expected difficulties (e.g., avoiding closed-endedness, using all four emotion-handling skills) and successes. Identify specific problems and give feedback about correcting them. Learners should role play solutions until all can perform the skills.

2. Teachers demonstrate a complete 5-step patient-centered interview of 5 minutes duration, concluding it with a transition and a few doctor-centered questions. Each learner then conducts a role play of all five steps of the patient-centered interview and concludes with a few doctor-centered questions. (60 minutes)
   a. This will be the next patient assignment and the initial bottom line for this course. Teachers need to come back to this goal repeatedly. By the end of the last session, all learners should be able to easily conduct and integrate the five steps.
   b. Teachers discuss misunderstandings and role play trouble spots, particularly moving from agenda to non-focused interviewing, active involvement in focused interviewing, establishing a personal focus, and transition to doctor-centered process.

3. Review 5-Step Patient-Centered Process (2 hours)
   a. Have learners perform entire patient-centered process (Steps 1-5) in a 15 minute interview, assigning non-interviewers to critique all sub-steps
   b. Encourage interviewers to identify specific areas, based on feedback they receive, to focus on for their next interview.
Teachers Guide

1. Begin each critique with an open-ended focus on learners' emotional responses. Teachers will find that learners have much anxiety about their first observed interview, are hard on themselves in critique, and are worried about how they did. Give positive as well as negative feedback, say what specific behavioral change is needed in the next interview, and be supportive and empathic.

2. Steps 1-5 are relatively easy to introduce and will be reinforced at all subsequent interviews. This work gives learners their first experience with the "real" interview.

3. By this point, learners should have a good grasp of questioning and relationship building skills, understand and define all specific skills, and be able to demonstrate all types of open-ended questions, emotion-seeking skills and emotion-handling skills. They should know how to use the skills to focus patients on a particular topic.

Learners' Assignment for Next Session

1. Review chapter 3
2. Perform entire patient-centered process (Steps 1-5) in a 15 minute interview with a real or simulated patient. Jointly review and critique it with a fellow learner prior to class and bring audio/videotaped interview for review at the next session, including the following:
   a. establish setting (Step 1)
   b. determine the agenda/chief complaint (Step 2)
   c. include a brief non-focused segment (Step 3) and at least a 10 minute focused segment, especially on the personal dimension of symptoms and emotions (Step 4)
   d. make transition to doctor-centered process with 1 minute of doctor-centered interviewing (Step 5)
SESSION 3: 5-Step Patient-Centered Process (2 Hours)

Objectives: same as Session 2

Small Group Work: General Comments

1. Instructors answer questions and have learners role play Steps 1 - 5 to demonstrate answers. Emphasize the important role of Step 4 and the centrality of actively focusing the conversation. Again, demonstrate focusing with active open-ended skills, emotion-seeking skills, and emotion-handling skills. Interviewers usually need to be pushed to be very active. Remind learners that Step 3 usually takes no more than 30 seconds and that it is the only time the interviewer does not focus the interview.

2. A key problem about content of the interview often arises and must be clarified. It is quite possible to remain patient-centered by repeated open-ended focus on physical symptoms. However, an entirely physical focus is not desired. Learners need to understand the personal and emotional dimensions of the physical story as well. Therefore, while one ensures that learners first elicit (open-endedly) the patient's personal description of physical symptoms, we also teach learners to change this focus (usually after 1-2 minutes) to the patient's personal life, typically the personal context of the physical symptoms. This is followed, in turn, by eliciting the emotional aspects of the patient's physical and personal life. Thus, we need to ensure that learners follow this three-step content sequence in each interview. For a review of this central point, refer to chapter 3 of the text.

3. Have learners define the use and role of the "core dynamic skills". As a result of actively focusing this sequence of skills, deep layers of the story develop with each repeat of the cycle of skills; e.g., is like peeling off layers of an onion to go progressively deeper into the personal and emotional story. This process deepens non-emotional as well as emotional material.

4. Remind learners that whatever skill is necessary to get a patient talking is appropriate with reticent patients.

5. Emotion-handling skills typically are not yet well incorporated, and it is usually necessary to remind learners of this (ie, NURS)

6. Encourage learners to use the patient-centered skills in their personal lives with spouses, friends and family. This leads to valuable discussion.
Small Group Work: Detailed Outline

1. Teachers review each interview, assigning non-interviewers to critique each step and its sub-steps. The instructor, however, always initiates discussion with inquiry about the learner's personal reaction to the patient and the interviewing circumstance. (110 minutes)

2. Conclude session with a demonstration (by teacher or learner) of the 5-step patient-centered interview and make suggestions on trouble spots. (10 minutes)

Teachers' Guide

1. Suggestions for interaction with the learner that can enhance the learner's sense of responsibility and self-direction:
   b. Before playing the tape, briefly ascertain how the experience went for the learner and what reactions she/he had
   c. Negotiate with each learner whether she/he would like to control the tape machine; with those learners who are having trouble, however, it may be necessary to stop the tape frequently so that learners know exactly what and where the problem is.
   c. When critiquing the tape, discuss learner's personal responses first. The teacher's use of NURS, as well as the learner's, continues to be the key. This initial self-awareness work usually takes no more than a few minutes.
   d. After discussing the learner's emotional responses, shift the focus to basic skills and feedback from the group.
   e. To conclude, the teacher might say, "Given the feedback the group is providing, what would be a useful focus for your next interview?"

2. An atmosphere promoting effective, constructive feedback can be enhanced by reinforcing respectfully proffered "negative" feedback among learners.

3. Common interviewing problems at this point may include:
   a. Inefficient agenda-setting
   b. Making a transition from agenda-setting (Step 2) to non-focused interviewing (Step 3) without an effective open-ended question
   c. Excessive passivity and prolonged non-focusing segments (Step 3) and/or failure to be active in the focusing segment
   d. Not recognizing emotional clues and not using emotion-seeking and emotion-handling skills
e. Difficulty achieving a personal focus if many physical symptoms are present
f. Not obtaining all three components of the patient-centered process: physical symptoms, personal life, and emotional story.

4. At this point, learners should:
   a. Know how to establish a flow of data
   b. Know how to develop the personal focus of both the immediate symptoms and the broader personal and emotional context of illness
   c. Be able to summarize a series of symptoms and other disease references and shift the focus to the personal context of these symptoms
   d. Be able to respectfully interrupt and redirect a patient when she/he wanders away from an important personal focus.

5. Teachers highlight that the learner is now “putting it all together” for the most difficult part of the interview.

6. If learners are having difficulty up to this point, instructors may need to assign review of previous content, have learners repeat previous interview assignments and/or offer individual mentoring. Additionally, appropriate segments of the text’s companion video can be individually viewed.

Learner’s Assignment for the Next Session

1. Read Chapter 7, pages 151-158 and pages 169-173.
2. Conduct a 15 minute patient interview with similar instructions from before, but focus primarily on identified problem areas. Use the full complement of emotion-seeking and emotion-handling skills at least three times.
SESSION 4: The Doctor-Patient Relationship (2 Hours)

Objectives: The learner should discuss and demonstrate the following:

1. Define the doctor-patient relationship (DPR) and its dyadic components. What are other influences on the DPR?
2. Why and how does the learner monitor the DPR? What characterizes a good DPR?
3. Discuss the obsessive-compulsive features of many physicians, why they occur, what is useful about them, what is potentially harmful and what might be done to decrease their negative impact on the patient.
4. What is a “personal response” as described in the text? Why is the interviewer the best focus for improving the DPR?
5. Distinguish between the interviewer’s unrecognized feelings and her/his unrecognized behaviors. Do these unrecognized responses feel good or bad to the interviewer?
6. What problems do unrecognized responses cause? How common are unrecognized responses towards patients? Do interviewers outgrow these responses as they gain experience? List the common unrecognized emotions and unrecognized behaviors, as shown in Table 7-1 of the text.
7. List several ways the learner can conduct “self analysis” to increase personal awareness of emotions.
8. Why can’t interviewers easily recognize these potentially harmful problems about themselves and, once recognized, easily change them? Is it possible for interviewers to prevent their emotions from becoming manifest?
9. Why is it valuable to develop self-awareness of unrecognized personal responses concerning other people as well as patients?
10. If one chooses to change, is the focus the behavior or the emotion or both? List several techniques the learner can use to assist change.
11. What principles are followed in working on self-awareness with colleagues?
12. Identify one positive and one negative emotion toward each interviewed patient
13. Over time, identify one or more previously unrecognized responses to patients or others that could be harmful.
Small Group Work: General Comments

1. Continue with questions about problems, using role play to illustrate answers.
2. The teacher introduces a new subject, the DPR, and discusses the objectives. As with the preceding material, discussions extend over many sessions and all material does not have to be covered in one session. Teachers should emphasize that unrecognized responses are universal and that most learners and physicians are psychologically healthy.
3. Discuss self-awareness issues, particularly common types that arise during an interview; see Table 7-1 of text.
4. It may be useful to discuss the following article, which can be assigned beforehand: Gabbard, G. (1985). The role of compulsiveness in the normal physician. JAMA, 254, 2926-2929.

Small Group Work: Detailed Outline

1. Instructor reviews tapes and learners critique interviews (90 minutes)
2. Discuss answers to DPR objectives. All objectives are not covered in this session, but are integrated over the remaining sessions. (30 minutes)

Teacher's Guide

1. Whenever the interviewer seems to miss the point or stop too early, inquire about her/his emotions. If she/he knows the skills and does not use them, an unrecognized personal response likely explains the failure.
2. Nearly all attention will be on Step 4 by this point; other Steps should have been mastered. Learners often need to be encouraged to “be so active that we have to tell you to back-off”. Learners should be able to:
   a. Use emotion-seeking and emotion-handling skills 4-6 times per interview
   b. Take both content and emotions to deeper levels by using repeated cycles of active open-ended followed by emotion-seeking followed by emotion-handling skills (core dynamic skills)
3. Learners also should not worry about pursuing the “right” personal clues to get the “best” story. Reassure them that as long as they are pursuing here/how and emotional or personal clues, the best/right story will emerge. Stories don't have to be complex and emotion-laden to be important; many patients have very straightforward situations.
Learners' Assignment for Next Session

1. Review prior reading
2. Repeat the last assignment and do a 15 minute interview. Pay particular attention to identified problem areas and to actively identifying and developing the patient's psychosocial story.
SESSION 5 (2 Hours)

Objectives: Review and discuss prior material

Small Group Work: General Comments

1. Questions, answers, role play and review
2. If time and satisfactory progress permit, introduce variations in use of the interview from Chapter 6 of the text. The instructor should be familiar with this chapter to answer questions that often arise.
3. Teachers continue discussing self-awareness

Small Group Work: Detailed Outline

1. Review tapes, addressing self-awareness and skills issues (90 minutes)
2. Continue general problem-solving discussions, demonstrations and role plays in addition to discussing the DPR (30 minutes)

Teacher's Guide

1. For all, but especially the reticent or otherwise non-progressing learners, it helps to have them critique the entire tape of another learner. Learners should be able to critique their own and others' tapes by this point, and should be doing it independently prior to class.
2. Have learners do brief role plays of difficult problems observed on their tapes, e.g., achieving a personal focus, interrupting effectively and respectfully, and being active.
3. Review some of the earlier material in Chapter 1 about the centrality of the patient-centered process that learners have begun to master—so they know the answer to “Why do all this?”

Learners' Assignment for the Next Session

Conduct a 15 minute patient interview and focus on identified problem areas. Identify individual areas of growth and areas that continue to need emphasis.
SESSION 6  (2 Hours)

Objectives: Steps 1-5

Small Group Work: General Comments

1. Questions and answers; review areas requested by learners
2. Use different clinical examples, including more complex cases

Small Group Work: Detailed Outline

1. Trouble shoot problems and role play their solutions during critique of taped interviews (90 minutes)
2. Reinforce learners regarding progress. Also, reinforce an ongoing respectful atmosphere and inquiry about patients' comfort once the doctor-centered process begins (30 minutes)

Teacher's Guide

1. Learners should have mastered Steps 1-5 and be familiar with self-awareness. Some may have made significant personal observations.
2. Periodically review how the personal, emotional and physical dimensions interact—and the value of this integrative approach. Learners now are being scientific as well as humanistic.
3. Learners should now have developed some confidence with the interviewing process.
4. If an individual is not progressing, instructors will need to determine whether this is related to knowledge, attitude or skills. The instructor and learner should discuss the issue and mutually problem solve. A learner may need to review a certain chapter, do an extra interview and/or develop a list of learning needs with a specific plan. Instructors can address attitudinal issues by using the “core dynamic skills” with the learner.

Learners' Assignment for Next Session

Read chapter 7, pages 158-169
SESSION 7: Personalities (2 Hours)

Objective: The learner should be able to discuss and demonstrate skills that show facility with the material related to patient personalities. The following objectives relate specifically to the Doctor-Patient Relationship (DPR):

1. Define personality style and contrast it to personality disorder. Discuss why the patient’s personality is important to the interviewer.
2. For each personality described (dependent, obsessive-compulsive, histrionic, self-defeating, narcissistic, paranoid and schizoid), discuss why the personality occurs; what are its general features in maladaptive and better adapted patients; how do maladaptive and better adapted patients present in the medical setting and what unique problems do they pose; discuss what problems these patients might pose for authoritarian and other type interviewers.
3. Discuss ways to enhance the DPR, particularly as it relates to personality styles that may be seen in underserved populations.

Small Group Work: Detailed Outline

1. Discuss and define the objectives. (30 minutes)
2. Spend most of the time demonstrating personality types in role play. Doing them as unknowns enhances interest and learning. (60 minutes)
3. Once the personality style is identified, demonstrate the unique management strategies for that personality in role play, with emphasis on “going with the flow” of the patient’s predominant personality feature. Include discussion related to underserved patients and remind learners that personality disorders typically require much additional management, usually by mental health professionals. (30 minutes)

Teacher’s Guide

1. Emphasize that diagnosing and responding to personalities begins during Steps 1-5 and that spotting features of a personality constitutes a hypothesis in need of open-ended corroboration in Step 4 and later.
2. For each personality, highlight the prominent diagnostic role of the following themes: control, intellectuality, emotionality, and ability to engage in a relationship.
3. Have learners give likely interactions of typical authoritarian interviewers with patients who have maladaptive personalities—and note whether the interaction would "feel" good or bad. Learners should know the common pitfalls most interviewers experience with each personality.

4. Rely on role playing in teaching about personalities. Learners usually enjoy playing the various personalities. An interviewer practices Steps 1-5 with the additional assignment of identifying the "patient’s" simulated personality. The simulation works best using the maladaptive patterns because the changes are easier to portray and recognize. Observers and teacher then give feedback on the interviewer’s skill in conducting Step 1-5 and everyone makes a diagnosis of the yet unknown personality. The teacher facilitates full discussion of the "hard data" for and against the various personality diagnoses. Facilitation of what this pattern looks like in normal patients is important as well.

Learners’ Assignment for Next Session

1. Review material on personality styles.
2. Perform entire patient-centered process (Steps 1-5) with a focus on determining the personality style. Review tape with an other learner prior to next class and be prepared to discuss and critique.
SESSION 8 (2 Hours)

Objective: Review and discuss prior material

Small Group Work

1. Review and critique tapes related to personality styles as well as Steps 1-5 (90 minutes)
2. Conclude session with a demonstration (by teacher or learner) of the 5 Step process and a focus on personality style; learners will discuss and critique demonstration (30 minutes)

Assignment for Session 9

Read section on nonverbal behavior in Chapter 7, pages 169-173
SESSION 9 (2 Hours)

Objective: The learner will be able to discuss and demonstrate skills related to the following nonverbal behavior in clinical situations:

Non-Verbal Behavior

1. Why are nonverbal behaviors important? Are they more or less important than verbal behaviors to understanding the patient? What is meant by a “mixed message” or a mind-body split when verbal and nonverbal behaviors are compared?
2. What can the interviewer do to ensure that his/her own nonverbal behaviors do not create an adverse reaction?
3. How does the interviewer address nonverbal behaviors when emotion is overtly expressed (emotion-handling skills), near the surface (emotion-seeking or focused open-ended skills) or when there is a mixed message (focused open-ended skills)?

Small Group Work: Detailed Outline

1. Discuss the objectives and review categories of nonverbal behaviors (30 minutes)
2. Demonstrate nonverbal expressions of emotion via role play. Have learners communicate entirely with nonverbal behaviors in role play while others identify the emotion and message being portrayed. Learners should develop understanding of some common nonverbal behaviors that can occur during an interview (eg., arms folded, leaning away, grimacing, tearing) (60 minutes)
3. Discuss and demonstrate nonverbal work with integrated patient-doctor interviewing (30 minutes)
The following exercises develop learners' appreciation of nonverbal behaviors:

a. Watch the videotape of a learner's interview with the sound turned off and identify nonverbal behaviors, what they signify about the interaction and whether learner and patient are synchronized or not
b. Role play different emotions using only nonverbal communication
c. Role play the positive and negative impact of various common nonverbal behaviors (e.g., too close, too far, excessive eye contact, no eye contact, arms folded, supportive touching, appropriate smiling, eye level interaction)

Assignment for Session 10

1. Perform entire patient-centered process (Steps 1-5) with a focus on nonverbal behavior
2. Review first audio/video tape and compare to final one. Be prepared to discuss individual interviewing progress and areas that need continued focus
SESSION 10 (2 Hours)

Objective: 5 Step Patient-Centered Process

Small Group Work

Depending on group progress and readiness, this final session may be used to comprehensively review the highlights of patient-centered interviewing and to evaluate individual progression and/or may focus on additional work related to nonverbal behavior.