

## Teaching Advanced Interviewing Skills to Residents: A Curriculum for Institutions with Limited Resources

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**Abstract:** Residency program directors currently face new requirements from the Accreditation Council for Graduate Medical Education (ACGME), including the mandate to demonstrate their residents' proficiency in communication skills. Such skills can be improved through an educational intervention, but few residencies specifically offer formal instruction in communication. Furthermore, the only formal instruction in communication skills described thus far for internal medicine residents requires hundreds of hours per month of faculty and resident time. This paper describes a time-efficient seminar series in communication skills for first-year internal medicine residents, which has been received well by faculty and learners as evidenced by post-seminar surveys and focus groups.

**Keywords:** clinical science education, evaluation, ambulatory education, education-housestaff, doctor-patient communication, interviewing, doctor-patient relationship

The medical interview is the "major medium of medical care."<sup>1</sup> By far, the patient's story alone yields most of the information needed for accurate diagnosis.<sup>2</sup> In various clinical settings, interviewing skills correlate positively with diagnostic accuracy,<sup>3</sup> patient adherence,<sup>4</sup> and satisfaction for both physicians and patients.<sup>5,6</sup> Patients who sue their physicians are much more often dissatisfied with the doctor-patient relationship than their physicians realize.<sup>7</sup>

Yet the interview is often taught and performed poorly.<sup>2,8-10</sup> Even clinicians with an interest in interviewing skills are often no more proficient than less interested colleagues.<sup>11</sup> Common problems include faulty data gathering as well as inattention to patients' emotional needs.<sup>12,13</sup> Patients are often interrupted before explaining the reason for their visit,<sup>14</sup> and they frequently believe that their expectations go unmet during clinic visits.<sup>15</sup>

Recognizing communications skills as one of the most important clinical skills, the Accreditation Council for Graduate Medical Education (ACGME) has recently required all American residency programs to demonstrate that their residents are proficient in communication skills.<sup>16</sup> The ACGME suggests several guides and assessment instruments for satisfying this requirement, but no consensus has emerged for demonstrating adequate instruction or proficiency of communication skills. The only recommendation extant in the medical literature

suggests formal instruction in communication skills that requires hundreds of hours for faculty and residents.<sup>17</sup>

Because my institution, like many others, does not have adequate resources to support such a large faculty and resident commitment, a shorter and less time-intensive course was developed using the same educational principles as those supported by previous research. The curriculum, its development and content, and strategies for implementation and evaluation are described in this paper.

### Description

The curriculum reflects the three functions of medical interviewing as described by Cohen-Cole. These functions are to 1) gather data to understand patients' problems; 2) develop rapport and respond to patients' emotions; and 3) educate and motivate patients.<sup>18</sup> Particular interviewing skills were chosen to emphasize the proper balance of patient- and doctor-centered interviewing as described by Smith.<sup>19</sup>

Four seminars, each three hours long, are conducted with the overall curricular goal of teaching internal medicine residents to interview patients effectively and empathically, using a proper balance of patient- and doctor-centered techniques, mirroring Cohen-Cole's three-function model. The goals for each seminar are enumerated below:

### Table 1. Assigned Reading

1. Beckman H, Markakis K, Suchman A, Frankel R. Getting the most from a 20-minute visit. *Am J Gastroenterol.* 1994;89:662-4.
2. Coulehan JL, Platt FW, Egener B. "Let me see if I have this right . . .": words that help build empathy. *Ann of Intern Med.* 2001;135:221-227.
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7. Levinson WL, Cohen MS, Brady D, Duffy FD. To change or not to change: "sounds like you have a dilemma." *Ann of Intern Med.* 2001;135:386-391.
8. Marvel MK, Epstein RM, Flowers K, Beckman HB. Soliciting the patient's agenda: have we improved? *JAMA.* 1999;281:283-287.
9. Smith RC, Hoppe RB. The patient's story: integrating the patient- and physician-centered approaches to interviewing. *Ann of Intern Med.* 1991;115:470-475.

1. Open a medical interview and set an agenda.
2. Explore patients' concerns, gathering sufficient data to make an accurate diagnosis.
3. Respond to patients' concerns and emotions empathically.
4. Close an interview, clearly stating diagnostic assessments and negotiating a plan for treatment and follow-up.

Each of the four seminars is delivered on a single morning when participants are freed from other clinical responsibilities. Seminars are conducted weekly so that the entire curriculum is completed at the end of a four-week period.

Seminars are conducted in small groups, consisting of four to six residents in their first post-graduate year (PGY-1) and one faculty facilitator. All seminars employ a similar format using multiple instructional venues (see

Appendix). Assigned reading (Table 1) and formal didactic instruction briefly introduce new material and provide a conceptual framework for learners. Next, the group reviews videotaped demonstrations ("trigger tapes") of the skills to be learned. These videotaped demonstrations feature faculty physicians interviewing real outpatients in a primary care internal medicine clinic. Most of these tapes were created in the faculty practice at my institution. The faculty invites each resident to reflect on his or her own skills and experiences, and to practice new interviewing skills using role-plays. Throughout the session, residents receive feedback from their peers. Residents may audio- or videotape their actual patient encounters for review in subsequent sessions, and facilities and equipment are made available for this purpose. Each three-hour seminar is conducted to maximize interactive group learning and minimize passive lecturing using approximately the following schedule:

#### Seminar Schedule

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|  |            |
|--|------------|
| Explore learners' individual experiences and learning needs  | 20 minutes |
| Didactic presentation of theory and evidence   | 30 minutes |
| Demonstration and discussion of interviewing behaviors and skills using previously videotaped encounters             | 30 minutes |
| Practice of new skills using role-play or other skill-building exercises   | 60 minutes |
| Reflection on individual practices and learning needs; commitment to implementing one new skill within the next week | 30 minutes |

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A Medical Interviewing Skills Inventory describes discrete interviewing tasks and behaviors (Table 2). The individual items on the inventory, identified through literature review and validated by content experts in the area of medical interviewing,<sup>20,21</sup> closely parallel the specific learning objectives (see Appendix) and reflect the chronological sequence of a typical encounter, beginning with agenda setting and ending with giving information. Residents and faculty refer to the Inventory during the didactic presentation, videotaped demonstrations and during skills practice. At the end of each seminar, the faculty asks residents to commit to practicing one or two of the skills described and practiced during that seminar.

Usually, residents choose an item from the Inventory that was previously unfamiliar to them.

A single faculty member, a general internist with an interest in medical interviewing and the doctor-patient relationship, conducts all sessions. At the time the course was implemented, he had completed a 1-year fellowship in medical curriculum development through the Primary Care Faculty Development Program offered by the Office of Medical Education Research and Development (OMERAD) at Michigan State University College of Human Medicine. This curriculum was developed with the help of OMERAD faculty, and it was reviewed

**Table 2. Medical Interviewing Skills Inventory**

A. Opening the interview and setting an agenda

The doctor:

1. greets patient
2. attends to patient privacy and comfort: noise & distractions minimized?
3. explicitly identifies purpose of interview and his/her own agenda to the patient
4. surveys patient's concerns and expectations within first five minutes
5. *if applicable*, negotiates priorities with patient
6. indicates amount of time available

B. Exploring problems and gathering data

The doctor:

1. establishes narrative thread using non-focused interviewing techniques (avoids leading questions)
2. uses facilitating remarks and gestures (e.g., "mm-hmm," echoing, nods) or uses silence
3. develops history using focused techniques: clarifies ambiguous information or redirects patient
4. identifies patient's attributions of illness
5. uses segmental summary: verifies information and checks own understanding
6. completes history using closed-ended questions: identifies remaining cardinal symptoms, inquires about pertinent family, social, and past medical history

C. Building a relationship and conveying empathy

The doctor:

1. makes appropriate eye contact
2. maintains an open posture
3. uses language appropriate for the patient's understanding
4. asks about the illness in the context of patient's life
5. acknowledges or asks about patient's emotions: uses PEARLS: partnership, empathy, apology, respect, legitimation, support
6. acknowledges the patient's accomplishments or challenges

D. Closing the interview; making a therapeutic plan

The doctor:

1. assesses patient knowledge, feelings, beliefs, or expectations regarding diagnosis and treatment
2. clearly states professional assessment in context of patient's concerns
3. clearly states professional recommendations, including potential alternatives, risks and benefits in context of patient's concerns
4. checks patient's understanding and acceptance of the diagnosis and recommendations
5. seeks to understand and negotiate differences
6. encourages patient (and family, if appropriate) to ask questions
7. establishes follow-up, including a contingency plan

for soundness of curricular design and content by two nationally-known experts. Since implementing this course, the local faculty member has gained expertise in the curricular content and small group teaching by completing the Facilitator-in-Training Program offered by the American Academy on Physician and Patient.

### Evaluation

Since this course was implemented four years ago, 36 PGY-1 internal medicine residents have completed structured self-assessments of their learning (100 percent response rate) immediately upon completing the curriculum. Of these, 32 report providing better overall care for patients in continuity clinic and greater confidence using patient-centered interviewing. Further, 34 residents continue to use at least one new skill learned in the course, and 29 feel more efficient when working in their continuity clinic.

Course participants also provide feedback on the course structure and teaching methods by participating in focus groups. Information obtained from these focus groups is used to plan future sessions. Learners consistently identify optimal group size for this seminar series between four and six participants (not including the faculty facilitator). Though unfamiliar with a learner-centered approach, such as identification of individuals' learning goals, residents appreciate the interactive nature of the experience. They comment that such teaching parallels, models and reinforces patient-centered interviewing as it is taught in the seminars.

Although participants favor interactive teaching and learning, the response to role-playing is more mixed. In focus groups conducted by the faculty immediately upon completion of the course, only about half the residents favored such exercises for their learning. The focus groups were structured by using a standard questionnaire administered to the residents. Data from these focus groups were analyzed by simple tabulation of responses to individual items on the questionnaire. Although all residents were offered the opportunity to video- or audiotape themselves during real encounters with patients, less than ten percent actually did so. Most felt uncomfortable reviewing tapes of themselves, either in private or in the small group, and stated this as the main reason for not recording patient encounters. All residents, however, "agreed" or "strongly agreed" with the statement on the course assessment asking whether the seminars were conducted in a "comfortable learning environment." Several commented during focus groups that such an experience should be added to the PGY-2 or PGY-3 curriculum as well.

### Discussion

Though research consistently shows that training in communication skills can improve the performance of learners,<sup>22-24</sup> curricula appear highly variable between institutions, both in quality and scope.<sup>25,26</sup> The extent of such experiences ranges from a single supervised encounter with a patient to highly structured courses using multiple educational venues and requiring more than one hundred hours per month of contact with devoted faculty.<sup>17,26</sup> Most residency training programs could not support the faculty time for such comprehensive courses. Indeed, many residency programs still offer no formal education in interviewing skills despite the recent ACGME requirements. New ACGME work-hour regulations will further constrain residency programs so that adding large blocks of learning experiences to an already intense schedule would be likely impossible.

The communications skills course described here has several strengths. First, for a moderately sized residency, it requires only 48 hours of faculty time per year assuming four three-hour sessions are offered to four different small groups during the academic year (18 residents per PGY 1 class). Second, residents overwhelmingly found it is a valuable experience in their curriculum. Third, they report greater confidence using several patient-centered interviewing skills and a greater range of interviewing behaviors. Finally, the didactic materials needed to teach the course are readily available, and teaching videotapes are easily produced.

The greatest limitation of this course, as currently constructed, is the lack of external, objective validation of improvement in residents' skills. Learner confidence has sometimes been used as a surrogate marker for competence, though research has shown conflicting results. Some research shows that confidence can increase commensurately with externally validated clinical competence.<sup>27</sup> Sometimes, however, an educational intervention can lead to increased confidence but no change in competence.<sup>28</sup> Alternately, learners may increase their competence without change in their self-assessed confidence.<sup>29</sup> Several variables could explain the inconsistent relationship between these two measures, including the quality of the teaching experience, the relevance of the subject to the learners, or other factors.

Though the ACGME does not yet specify how program directors measure their residents' communication skills, it does require that residents clearly demonstrate skill proficiency.<sup>16</sup> To date, there is no published literature or general consensus on what a minimum expectation of communication skills should be. Further research

will be required before program directors can rely exclusively on residents' self-assessment of their confidence as a surrogate measure of communication skills. In the meantime, program directors could consider using a communications skills curriculum, such as the one described here, as a forum in which to conduct the Mini-Clinical Evaluation Exercise (Mini-CEX), recommended by the American Board of Internal Medicine (ABIM) and the ACGME.<sup>30</sup> The Mini-CEX shows good psychometric properties in its ability to assess basic clinical skills such as interviewing, and it could be used as an external measure by which to assess the impact of the course on clinical competence. We plan to strengthen our curriculum by adding external validation through the use of objective structured clinical exercises (OSCE) and by review of actual videotaped clinical encounters. External validation of residents' performance that improves as a result of the interviewing course described here would be the first validation of a short, relatively time-efficient educational intervention in the domain of communication skills training.

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**Appendix. Detailed Seminar Objectives**

Objectives: Seminar 1 (Opening an interview and negotiating an agenda)

| Learning Objectives   | Content  | Instructional Strategies  | Learner Evaluation Methods   |
|---|--|---|--|
| <p>1. Given a videotaped encounter between a faculty physician and a real patient in an ambulatory setting, residents will correctly identify:</p> <ul style="list-style-type: none"> <li>a. patient &amp; doctor-centered interviewing techniques</li> <li>b. focused &amp; non-focused interviewing techniques</li> <li>c. function of interview</li> </ul> <p>as described by Smith and Cohen-Cole.</p>  | <p>1. Theoretical background:</p> <ul style="list-style-type: none"> <li>a. patient- vs. doctor-centered interviewing</li> <li>b. focused &amp; non-focused interviewing</li> <li>c. three-function model of medical interviewing</li> </ul> | <ul style="list-style-type: none"> <li>• Assigned reading</li> <li>• Didactic presentation</li> <li>• Videotaped demonstration (“trigger tapes”)</li> <li>• Medical Interviewing Checklist</li> <li>• Optional reading</li> </ul> | <ul style="list-style-type: none"> <li>• Medical Interviewing Checklist</li> </ul>   |
| <p>2. Given i) a videotaped encounter between a faculty physician and a real patient in an ambulatory setting, ii) an audiotape provided by the resident, and iii) a role-play scenario, residents will correctly identify:</p> <ul style="list-style-type: none"> <li>a. doctor greeting patient</li> <li>b. attention to patient privacy and comfort</li> <li>c. doctor identifying own agenda to patient</li> <li>d. doctor surveying patient’s concerns</li> <li>e. negotiation of priorities</li> <li>f. doctor indicates amount of time available</li> </ul> <p>sufficient to make an accurate diagnosis.</p> | <p>2. Identification of specific behaviors (see left)</p>  | <ul style="list-style-type: none"> <li>• Videotaped demonstration (“trigger tapes”)</li> <li>• Review of audiotapes</li> <li>• Role-play</li> <li>• Medical Interviewing Checklist</li> </ul>                                     | <ul style="list-style-type: none"> <li>• Medical Interviewing Checklist</li> <li>• Structured feedback from peers and faculty facilitator</li> <li>• Final exam</li> </ul> |

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| <p>3. Given an encounter with a real patient in an ambulatory setting, residents will:</p> <ul style="list-style-type: none"> <li>a. greet the patient</li> <li>b. attend to patient privacy and comfort</li> <li>c. identify own agenda to patient</li> <li>d. survey patient's concerns</li> <li>e. negotiate of priorities</li> <li>f. indicate amount of time available to gather information</li> </ul> <p>sufficient to make an accurate diagnosis in under twenty minutes.</p> | <p>3. Skill building and practice of specific interviewing behaviors (see left)</p> | <ul style="list-style-type: none"> <li>• Review of audiotapes</li> <li>• Role-play and feedback</li> <li>• Medical Interviewing Checklist</li> </ul> | <ul style="list-style-type: none"> <li>• Medical Interviewing Checklist</li> <li>• Final exam</li> </ul> |
|---|---|--|--|

Objectives: Seminar 2 (Exploring Problems and Gathering Data)

| Learning Objectives   | Content   | Instructional Strategies  | Learner Evaluation Methods   |
|---|---|---|--|
| <p>I. Given a videotaped encounter between a faculty physician and a real patient in an ambulatory setting, residents will correctly identify:</p> <p>a. patient &amp; doctor-centered interviewing techniques</p> <p>b. focused &amp; non-focused interviewing techniques</p> <p>c. function of interview</p> <p>as described by Smith and Cohen-Cole.</p> | <p>I. Theoretical background:</p> <p>a. patient- vs. doctor-centered interviewing</p> <p>b. focused &amp; non-focused interviewing</p> <p>c. three-function model of medical interviewing</p> | <ul style="list-style-type: none"> <li>• Assigned reading</li> <li>• Didactic presentation</li> <li>• Videotaped demonstration (“trigger tapes”)</li> <li>• Medical Interviewing Checklist</li> <li>• Optional reading</li> </ul> | <ul style="list-style-type: none"> <li>• Medical Interviewing Checklist</li> </ul> |

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| <p>2. Given i) a videotaped encounter between a faculty physician and ambulatory setting, ii) an audiotape provided by the resident, and iii) a role-play scenario, residents will correctly identify:</p> <ul style="list-style-type: none"> <li>a. narrative thread using non-focused interviewing techniques</li> <li>b. use of facilitating remarks and gestures or use silence</li> <li>c. clarification of ambiguous information or redirection of patient</li> <li>d. patient's attributions of illness</li> <li>e. use of a segmental summary</li> <li>f. completion of history using closed-ended questions</li> </ul> <p>sufficient to make an accurate diagnosis.</p> | <p>2. Identification of specific behaviors (see left)</p> | <ul style="list-style-type: none"> <li>• Videotaped demonstration ("trigger tapes")</li> <li>• Review of audio-tapes</li> <li>• Role-play</li> <li>• Medical Interviewing Checklist</li> </ul> | <ul style="list-style-type: none"> <li>• Medical Interviewing Checklist</li> <li>• Structured feedback from peers and faculty facilitator</li> <li>• Final exam</li> </ul> |
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| <p>3. Given an encounter with a real patient in an ambulatory setting, residents will:</p> <ul style="list-style-type: none"> <li>a. establish a narrative thread using non-focused interviewing techniques</li> <li>b. use facilitating remarks and gestures or use silence</li> <li>c. clarify ambiguous information or redirect the patient</li> <li>d. identify patient's attributions of illness</li> <li>e. use a segmental summary</li> <li>f. complete the history using closed-ended questions to gather information</li> </ul> <p>sufficient to make an accurate diagnosis in under twenty minutes.</p> | <p>3. Skill building and practice of specific interviewing behaviors (see left)</p> | <ul style="list-style-type: none"> <li>• Review of audiotapes</li> <li>• Role-play and feedback</li> <li>• Medical Interviewing Checklist</li> </ul> | <ul style="list-style-type: none"> <li>• Medical Interviewing Checklist</li> <li>• Final exam</li> </ul> |
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Objectives: Seminar 3 (Building a relationship and establishing empathy)

| Learning Objectives  | Content  | Instructional Strategies  | Learner Evaluation Methods   |
|--|--|---|--|
| <p>1. Given a videotaped encounter between a faculty physician and a real patient in an ambulatory setting, residents will correctly identify:</p> <ul style="list-style-type: none"> <li>a. patient &amp; doctor-centered interviewing techniques</li> <li>b. focused &amp; non-focused interviewing techniques</li> <li>c. function of interview</li> </ul> <p>as described by Smith and Cohen-Cole.</p>   | <p>1. Theoretical background:</p> <ul style="list-style-type: none"> <li>a. patient- vs. doctor-centered interviewing</li> <li>b. focused &amp; non-focused interviewing</li> <li>c. three-function model of medical interviewing</li> </ul> | <ul style="list-style-type: none"> <li>• Assigned reading</li> <li>• Didactic presentation</li> <li>• Videotaped demonstration (“trigger tapes”)</li> <li>• Medical Interviewing Checklist</li> <li>• Optional reading</li> </ul> | <ul style="list-style-type: none"> <li>• Medical Interviewing Checklist</li> </ul>   |
| <p>2. Given i) a videotaped encounter between a faculty physician and a real patient in an ambulatory setting, ii) an audiotape provided by the resident, and iii) a role-play scenario, residents will correctly identify:</p> <ul style="list-style-type: none"> <li>a. appropriate eye contact</li> <li>b. open posture</li> <li>c. language appropriate for the patient’s understanding</li> <li>d. history of illness in context of patient’s life</li> <li>e. acknowledge/ ask about patient’s emotions</li> <li>f. legitimization of expressed emotions</li> <li>g. acknowledge patient’s accomplishments or challenges</li> </ul> <p>sufficient to build an empathic relationship.</p> | <p>2. Identification of specific behaviors (see left)</p>  | <ul style="list-style-type: none"> <li>• Videotaped demonstration (“trigger tapes”)</li> <li>• Review of audiotapes</li> <li>• Role-play</li> <li>• Medical Interviewing Checklist</li> </ul>                                     | <ul style="list-style-type: none"> <li>• Medical Interviewing Checklist</li> <li>• Structured feedback from peers and faculty facilitator</li> <li>• Final exam</li> </ul> |

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| <p>3. Given an encounter with a real patient in an ambulatory setting, residents will:</p> <ul style="list-style-type: none"> <li>a. make appropriate eye contact</li> <li>b. maintain an open posture</li> <li>c. use language appropriate for the patient's understanding</li> <li>d. elicit history of illness in context of patient's life</li> <li>e. acknowledge/ ask about patient's emotions</li> <li>f. legitimate any expressed emotions</li> <li>g. acknowledge patient's accomplishments or challenges</li> </ul> <p>sufficient to build an empathic relationship.</p> | <p>3. Skill building and practice of specific interviewing behaviors (see left)</p> | <ul style="list-style-type: none"> <li>• Review of audiotapes</li> <li>• Role-play and feedback</li> <li>• Medical Interviewing Checklist</li> </ul> | <ul style="list-style-type: none"> <li>• Medical Interviewing Checklist</li> <li>• Final exam</li> </ul> |
|--|---|--|--|

Objectives: Seminar 4 (Closing the interview and making a therapeutic plan)

| Learning Objectives  | Content  | Instructional Strategies  | Learner Evaluation Methods   |
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| <p>1. Given a videotaped encounter between a faculty physician and a real patient in an ambulatory setting, residents will correctly identify:</p> <ul style="list-style-type: none"> <li>a. patient &amp; doctor-centered interviewing techniques</li> <li>b. focused &amp; non-focused interviewing techniques</li> <li>c. function of interview as described by Smith and Cohen-Cole.</li> </ul>  | <p>1. Theoretical background:</p> <ul style="list-style-type: none"> <li>a. patient- vs. doctor-centered interviewing</li> <li>b. focused &amp; non-focused interviewing</li> <li>c. three-function model of medical interviewing</li> </ul> | <ul style="list-style-type: none"> <li>• Assigned reading</li> <li>• Didactic presentation</li> <li>• Videotaped demonstration (“trigger tapes”)</li> <li>• Medical Interviewing Checklist</li> <li>• Optional reading</li> </ul> | <ul style="list-style-type: none"> <li>• Medical Interviewing Checklist</li> </ul>   |
| <p>2. Given i) a videotaped encounter between a faculty physician and a real patient in an ambulatory setting, ii) an audiotape provided by the resident, and iii) a role-play scenario, residents will correctly identify:</p> <ul style="list-style-type: none"> <li>a. clear statement of doctor’s assessment in context of patient’s concerns</li> <li>b. clear statement of doctor’s recommendations</li> <li>c. check of patient’s understanding and acceptance of diagnosis and recommendations</li> <li>d. doctor seeking to understand and negotiate differences</li> <li>e. opportunity for patient/family to ask questions</li> <li>f. follow-up and contingency plan</li> </ul> <p>sufficient to ensure adequate treatment of patient’s condition.</p> | <p>2. Identification of specific behaviors (see left)</p>  | <ul style="list-style-type: none"> <li>• Videotaped demonstration (“trigger tapes”)</li> <li>• Review of audio-tapes</li> <li>• Role-play</li> <li>• Medical Interviewing Checklist</li> </ul>                                    | <ul style="list-style-type: none"> <li>• Medical Interviewing Checklist</li> <li>• Structured feedback from peers and faculty facilitator</li> <li>• Final exam</li> </ul> |

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| <p>3. Given an encounter with a real patient in an ambulatory setting, residents will:</p> <ul style="list-style-type: none"> <li>a. clearly state diagnostic assessment in context of patient's concerns</li> <li>b. clearly state medical recommendations</li> <li>c. check patient's understanding and acceptance of diagnosis and recommendations</li> <li>d. seek to understand and negotiate differences</li> <li>e. allow opportunity for patient/family to ask questions</li> <li>f. make follow-up and contingency plan</li> </ul> <p>sufficient to ensure adequate treatment of patient's condition.</p> | <p>3. Skill building and practice of specific interviewing behaviors (see left)</p> | <ul style="list-style-type: none"> <li>• Review of audiotapes</li> <li>• Role-play and feedback</li> <li>• Medical Interviewing Checklist</li> </ul> | <ul style="list-style-type: none"> <li>• Medical Interviewing Checklist</li> <li>• Final exam</li> </ul> |
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