- **Cole, Steven A.; Bird, Julian (2013-12-14). The Medical Interview: The Three Function Approach (Kindle Locations 420-422). Elsevier Health Sciences. Kindle Edition.**

F1 Build an effective relationship

Concerns the relationship and employs skills focused on the emotional domain of the interview, including engagement, rapport, mutual respect, trust, expression of empathy, and development of the affective connection for a working alliance.

F2 Assess and understand the patient's problems

Inductive and deductive information-gathering techniques to diagnose, assess, and understand patient problems as well as the patient as a person who is experiencing those problems;

F2 Goal

 Collection of accurate, sufficient, and relevant data, as efficiently as possible. Understanding the patient's "explanatory model" of his or her symptoms , realizing the impact of illness on the patient's quality of life, and appreciating the patient's expectations and preferences for the encounter all contribute to achieving optimal outcomes through the collaborative management process (F3).

- Suchman, AL, Hinton-Walker, P, Botelho, RJ. Partnerships in healthcare: transforming relational process. Rochester: University of Rochester Press; 1998.
- Yedidia, MJ, et al. Effect of communications training on medical student performance. JAMA. 2003; 290(9): 1157– 1165.
- Eisenthal, S, et al . "Adherence" and the negotiated approach to patienthood. Arch Gen Psychiatry. 1979; 36(4): 393– 398.
- Kleinman, A, Eisenberg, L, Good, B. Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. Ann Intern Med. 1978; 88(2): 251– 258.

F3 Collaboratively manage problems

Education, patient activation, shared decision making, self-management support, and motivational skills to facilitate collaboration for management of patient problems.

F 3: Collaborate for Management

Educate patients for shared decision making,

Support patient self-management,

Motivate patients for adaptive health behaviors.

addresses all of these separate but related objectives, it is clearly the most complex of the three functions of the interview

F1 Build the Relationship

- Clinicians with good relationship skills will have patients who are more satisfied and who will be more likely to adhere to treatment recommendations.

- Roter, DL, Hall, JA. Communication and adherence: moving from prediction to understanding. Med Care. 2009; 47(8): 823– 825.

Group of basic skills that help build the clinician-patient relationship:

 (1) nonverbal skills;

(2) reflection;

(3) legitimation;

(4) support;

(5) partnership; and

(6) respect.

Nonverbal Skills

- The nonverbal behavior of the physician contributes significantly to the overall quality of the doctor-patient relationship.

- Roter, DL, et al. The expression of emotion through nonverbal behavior in medical visits. Mechanisms and outcomes. J Gen intern Med. 2006; 21(Suppl 1): S28– S34.

- Quiet, attentive listening conveys interest and builds rapport more powerfully than virtually any other action or utterance the physician can make.

- Roter, DL, et al. The expression of emotion through nonverbal behavior in medical visits. Mechanisms and outcomes. J Gen intern Med. 2006; 21(Suppl 1): S28– S34.

- Hall, JA , et al. Nonverbal sensitivity in medical students: implications for clinical interactions. J Gen Intern Med. 2009; 24(11): 1217– 1222.

- Doctors who establish appropriate eye contact are more likely to detect emotional distress in their patients.

- Goldberg, DP, et al. Training family doctors to recognize psychiatric illness with increased accuracy. Lancet. 1980; 2(8193): 521– 523.

- Doctors who lean forward and have an open body posture also have more satisfied patients.

- Roter, DL, et al. The expression of emotion through nonverbal behavior in medical visits. Mechanisms and outcomes. J Gen intern Med. 2006; 21(Suppl 1): S28– S34.

- Hall, JA , et al. Nonverbal sensitivity in medical students: implications for clinical interactions. J Gen Intern Med. 2009; 24(11): 1217– 1222.

- Halpern, J. What is clinical empathy? J Gen Intern Med. 2003; 18(8): 670– 674.

Empathy

- Empathy starts with an individual's appreciation, understanding, and acceptance of someone else's life situation.

- The communication of this understanding and acceptance completes the empathic process and becomes, in virtually every situation, the most helpful, meaningful, and comforting intervention one person can have with another.

Reflection

Refers to the physician recognizing and naming the emotional or cognitive response of the patient;

- *physician: You look sad right now.*

- *or physician: I can see this is upsetting to you.*

- *or physician: This is hard to talk about.*

It is generally helpful and supportive to allow patients the opportunity to express verbally the feelings that are near the surface of awareness. Furthermore, despite the belief that such attention to the emotional domain of patient care increases interview time, research indicates the contrary: after training, empathic communication by primary care physicians improved numerous outcomes of importance (*e.g., recognition of emotional disorders, patient satisfaction, disclosure of information, and decreased emotional distress*) **without increasing overall interview time**.

- Roter, D, Hall, JA. Doctors talking with patients/ patients talking with doctors: improving communication in medical visits, ed 2. Westport, Conn.: Praeger; 2006.
- Gerrity, MS, et al. Improving the recognition and management of depression: is there a role for physician education? J Fam Pract. 1999; 48(12): 949– 957.
- Roter, DL, et al . Improving physicians' interviewing skills and reducing patients' emotional distress. A randomized clinical trial. Arch Intern Med. 1995; 155(17): 1877– 1884.

Rule #1

Respond to patient's feelings as soon as they appear.

Legitimation

or validation, refers to the physician's confirming that the response is understandable and acceptable.

Is closely related to reflection but indicates an intervention that specifically communicates acceptance of and respect for the patient's emotional experience.

Personal Support

Statements of personal support enhance rapport. The physician should make explicit efforts to reassure the patient that he or she is there and wants to help, limited self-disclosure is also appropriate.

Partnership

Patients are more satisfied with physicians and are more likely to adhere to treatment recommendations when they feel a sense of partnership with their physicians.

Dye, NE, DiMateo, MR. Enhancing cooperation with the medical regime. In: Lipkin M, Jr., eds. The medical interview: clinical care, education, and research. NY. P: Springer; 1995: 134– 136.

Increasing the participation of a patient in his or her treatment improves coping skills and increases the likelihood of a good outcome .

Roter, DL, Hall, JA. Communication and adherence: moving from prediction to understanding. Med Care. 2009; 47(8): 823– 825.

Respect (Affirmation)

The physician's respect for patients and their problems is implied by attentive listening, specific nonverbal signals, eye contact, and genuine concern. However explicit, respectful comments also help build rapport, improve relationships, and help patients cope with complex situations.

P(E) ARLS

Five skills to build the relationship:

- Partnership
- (Empathy), expressed through reflection and legitimation
- Affirmation (respect)
- Reflection
- Legitimation
- Support

F2: Assess and Understand

1. Nonverbal listening behavior
2. Questioning style: open-ended questions and the open-to-closed cone
3. Rule #2: Let the patient complete the opening statement.
4. Facilitation
5. Clarification and direction
6. Checking/ summarizing
7. Rule #3: When in doubt, check.
8. Survey problems: What else?
9. Avoid leading questions.
10. Elicit the P's perspective: " ICE".
11. Explore the impact of the illness on the P's quality of L.

Atviri klausimai

– prasideda *Kaip...? Ko...? Kam...? Ką...? Koks...?*

– puikiai tinka pokalbio pradžiai;

– paskatinti pašnekovą kalbėti;

– padeda susirinkti info;

– atsakingu už pokalbį jaučiasi pašnekovas, jūs - klausotės ir atsirenkat jums reikalingą info.

Uždari klausimai

– dažniausiai prasideda „*ar*"
– leidžia patikslinti faktus;
– riboja pašnekovo kalbėjimą;
– padeda valdyti, struktūruoti pokalbį;
– naudojant daug uždarų klausimų, atsakomybė už pokalbį tenka jums, o pašnekovas pasyviai laukia naujo klausimo;

Klausimai

– Paprasti, aiškūs;
– Vienu klausimu neklausti kelių dalykų;
– Klausiant nesiūlyti atsakymų.
– Klausti be išankstinės nuostatos

Communication roadbloks

1. Ordering, directing, commanding
2. Warning, admonishing, threatening
3. Moralizing, preaching
4. Name-calling, labeling
5. Judging, blaming
6. Disagreeing, contradicting, teaching
7. Agreeing, supporting, praising
8. Interpreting, analyzing
9. Reassuring, sympathizing
10. Ignoring, diverting, withdrawing, interrupting
11. Questioning, probing
12. Advising, giving solutions

TED talks

Amy Cuddy

Your body language shapes who you are

Galvos skausmas I

- *physician: What can I do for you today?*
- *patient: I've been having terrible headaches.*
- *physician: I'm sorry. Where is the pain?*
- *patient: The pain is all over.*
- *physician: Is the pain sharp or dull?*
- *patient: Dull.*
- *physician: Does the pain come and go, or is it there all the time?*
- *patient: It comes and goes. But when the headache comes, it may be there for several days.*

Galvos skausmas II

- *physician: What can I do for you today?*
- *patient: I've been having terrible headaches.*
- *physician: Can you tell me some more about these headaches?*
- *patient: Well, they come on slowly and get worse and worse over several days. They seem to come only in the hay fever season when my allergies get worse.*

Galvos skausmas III

- *physician: Can you tell me some more about your headaches?*

- *patient: Well, they only started about 3 weeks ago and seem to come on when I'm in the library late at night studying for exams.*

Rule #2

Let the Patient Complete the Opening Statement!

Checking (or summarizing)

Checking feels reassuring to the patient because he or she realizes the doctor is interested in gaining an accurate understanding of the problem, and this promotes trust as well as the patient's experience of the physician as caring.

It also allows the patient the opportunity to correct any misinformation that is presented.

☺

Beginning interviewers, in particular, find checking useful to help manage their own anxiety while trying to conduct an efficient interview.

Rule #3

When in Doubt, Check

Survey Problems: "What Else?"

- "What else is bothering you?" to be the most important question he asks his patients.

- Sometimes, if the physician directs the interview too strongly, patients may be too anxious to remember to discuss all their concerns, or there are simply too many to get to.

- *"Oh, by the way, doctor ... is this chest pain important?"*

"What else is bothering you? " vs.

"Is there anything else bothering you?".

"You don't have any other problems, do you?"

The clinician should continue asking, "What else is bothering you?" until the patient indicates that all the problems have been mentioned.

Leading questions can result in significant and sometimes dangerous misinformation:

physician: The pain doesn't go down your arm, does it?

patient: No, not really.

"How helpful was the medication I gave you?"

What effects, good and bad, did the medication have?

Patient's Perspective - ICE

- Explore the Patient's **Ideas** about the Meaning of the Illness

- Elicit the Patient's **Concerns** about the Problems

- Elicit the Patient's **Expectations**

- Eisenthal, S, Lazare, A. Evaluation of the initial interview in a walk-in clinic. The clinician's perspective on a "negotiated approach.". J Nerv Ment Dis. 1977; 164(1): 30– 35.

- Eisenthal, S, Koopman, C, Lazare, A. Process analysis of two dimensions of the negotiated approach in relation to satisfaction in the initial interview . J Nerv Ment Dis. 1983; 171(1): 49– 54.

- Eisenthal, S, et al . "Adherence" and the negotiated approach to patienthood. Arch Gen Psychiatry. 1979; 36(4): 393– 398.

Impact of the Illness on the Patient's Quality of Life

This includes the impact on

(1) interpersonal relationships (*especially spouse, significant other, and family*),

(2) work,

(3) sexual relationships, and

(4) emotional stability.

Social stress and social support

- For example, among patients experiencing their first heart attacks, those patients with low support and high stress were four times more likely to die of a repeat heart attack in the subsequent year.

- Rozanski, A, et al. The epidemiology , pathophysiology, and management of psychosocial risk factors in cardiac practice: the emerging field of behavioral cardiology. J Am Coll Cardiol. 2005; 45(5): 637– 651.

The CAGE interview

Helpful in eliciting information suggestive of alcohol abuse. Ewing, JA. Detecting alcoholism: the CAGE questionnaire. JAMA. 1984; 252: 1905.

- C Have you ever felt the need to **cut down** on your drinking?

- A Do you ever get **annoyed** when people tell you to cut down on your drinking?

- G Do you ever feel **guilty** about drinking too much?

- E Have you ever needed an "**eye-opener**" in the mornings?

If the patient answers yes to any of the four questions of the CAGE model, the possibility of alcohol abuse or risky drinking is present and must be explored in more detail.

Mental illnesses

- Mental illness is common in the general population (about 20% of the population over any 6-month period of time) and among patients seeking general medical care. Regier, DA, et al. The de facto U.S. mental and addictive disorders service system. Epidemiologic catchment area prospective 1-year prevalence rates of disorders and services. Arch Gen Psych. 1993; 50: 85– 94.

- Carefully conducted studies have revealed that 25% to 33% of primary care patients suffer from a mental disorder and another 20% have significant emotional problems or symptoms complicating their physical illnesses.

- One third to one half of these problems are not recognized by primary care physicians.

- Kessler, RC, et al. Prevalence and treatment of mental disorders, 1990-2003. N Engl J Med. 2005; 352(24): 25.

Six-point mental status assessment

Can be elicited without any specific questioning:

       1. General appearance/ behavior

       2. Speech/ language

       3. Mood/ affect

       4. Thought/ perception

       5. Cognition/ sensorium

       6. Insight/ judgment

F3 COLLABORATE FOR MANAGEMENT

1. Education about illness
2. Self-management support tool ≈ Brief Action Planning (BAP) ↔ Motivational interviewing (MI).

Education about illness

Use (e) TACCT:

elicit patient's baseline understanding of the problem.

Tell the patient the core message.

Ask the patient for his or her understanding of the condition and his or her reaction.

Care by responding to the emotional impact (using Function One skills).

Counsel the patient about the details of the educational message.

Tell-back: Ask the patient to "T ell-back" the core details of the message.

Brief Action Planning

1. Elicit patient ideas for change
2. Offer a behavioral menu when needed or helpful
3. SMART behavioral planning (iš MI,)
4. Elicit the commitment statement
5. Question Two: Scale for confidence (kiek realu, kad įvykdysite tai, apie ką tarėmės, skalė 1-10; ok, kai ↑7)
6. Problem solving to increase confidence level when necessary (koreguojamas susitarimas adekvatesniu)
7. Arrange accountability (Kaip, kokiais vnt vertinsite rezultatą)
8. Follow-up

Six-Step Problem-Solving System

- Step 1: Defining the Problem
- Step 2: Generating Alternative Solutions
- Step 3: Evaluating Alternative Solutions
- Step 4: Deciding on a Mutually Acceptable Solution
- Step 5: Implementing the Solution (Who does what by when?)
- Step 6: Evaluating the Effectiveness of the Solution ("How long do we have to wait?"They might agree on a date for a follow-up visit for this feedback.)