INTERVIEW RATING FORM: PHYSICIAN

TRAINING MANUAL AND REFERENCE

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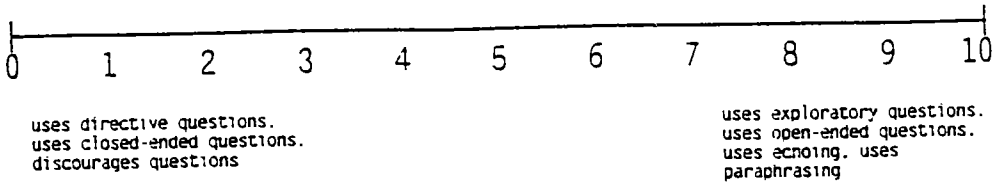
1. The physician <u>encourages</u> patient responses.



This item is designed to assess the degree to which the physician actively facilitates the interview. Here we are concerned with physician behaviors such as the use of open-ended and exploratory questions, echoing, paraphrasing, and other active behaviors that indicate to the patient that he/she should continue talking about a topic.

[0-2] The physician is closed-ended and actively discouraging patient responses by interrupting the patient, cutting the patient off, or ignoring or dismissing the patient's responses.

[3-5] The physician is primarily closed-ended but is not actively discouraging the patient from responding.

[5-7] The physician is more open-ended but is not actively encouraging patient responses.

[8-10] The physician is open-ended and actively encouraging patient responses by using facilitation techniques such as asking exploratory and open-ended questions, echoing, etc.

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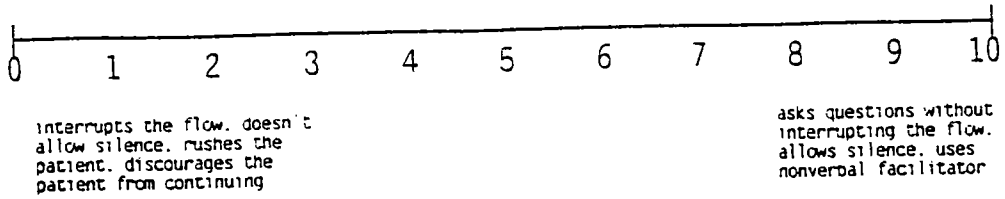
2. The physician allows the patient to talk.



This item is designed to assess the degree to which the physician facilitates the interview in a more passive manner. To some extent we are concerned with things the interviewer does NOT do that facilitate the interview - not talking, not interrupting, etc.

[0-2] The physician prevents the patient from talking by interrupting, cutting the patient off, talking over the patient, rushing the patient, etc.

[3-5] The physician limits the patient's opportunity to talk by interrupting, cutting the patient off, etc. The patient is allowed to answer specific questions but is not allowed to expand on topics.

[5-7] The physician allows the patient to take his/her turn of talk without interrupting. The physician <u>does not provide</u> opportunities for the patient to lead the discussion or expand on topics but allows the patient to expand on topics if he/she takes the initiative.

[8-10] The physician gives the patient the opportunity to lead the discussion. (The patient doesn't have to take it.) The physician "sits back and lets the patient go." The physician uses silence and other nonverbal facilitators to give the patient an opportunity to expand on topics.

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3. The physician responds <u>appropriately</u> to the patient's signs of feeling and emotion.

0 1 2 3 4 5 6 7 8 9 10

does not pay attention to or inquire about the patient's feelings and emotions

listens attentively and/ or inquires about the patient's feelings and emotions

_____ No emotion was expressed by the patient.

This item is designed to assess the degree to which the physician responds appropriately to the patient's emotional cues. Two key dimensions of emotional cues are the clarity with which they are presented and the seriousness/intensity of the concern. A patient's cue may be pretty clear and obvious (e.g. "I'm really worried about what this might be.") or it may be more subtle (e.g. hand wringing, knitted brow). A patient's concerns may be quite serious (e.g. a fear of serious disease or death) or they may less serious (e.g. a fear of needles). For a physician's response to be appropriate, it must be timely and must match the intensity or seriousness of the concern as presented by the patient.

[0-2] The physician misses or ignores clear cues about serious concerns.

[3-5] The physician misses or ignores more subtle cues and/or cues about less serious concerns.

[5-7] The physician acknowledges the patient's cues but does not pursue them. The high end of this range would include naming emotions and making statements of understanding.

[8-10] The physician acknowledges the patient's cues (or inquires about feelings and concerns) and actively pursues them. (e.g. "You said you were concerned about missing work. Tell me more about that.")

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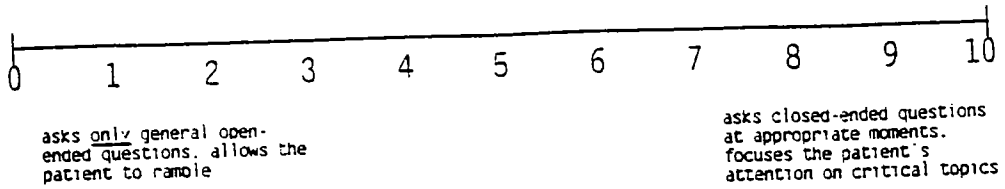
4. The physician directs the patient to <u>pursue</u> biomedical topics.



This item is designed to assess the degree to which the physician uses a variety of skills to obtain the patient's biomedical story. There are two components to this. One is directing the patient - keeping the patient focused on critical biomedical topics. The other is actively seeking out additional information about those biomedical issues (e.g. symptoms).

[0-2] The physician provides no focus or direction for the interview, is extremely passive and allows the patient to wander from topic to topic. He/she ignores biomedical data offered by the patient. (This category includes not addressing biomedical topics at all.)

[3-5] The physician lets the patient talk about biomedical issues but does not probe the patient for more information.

[5-7] The physician allows the patient to determine which biomedical topics are discussed. The physician pursues these topics.

[8-10] The physician actively provides focus and direction for the interview. This includes seeking clarification and expansion of biomedical data and the introduction of new and related topics.

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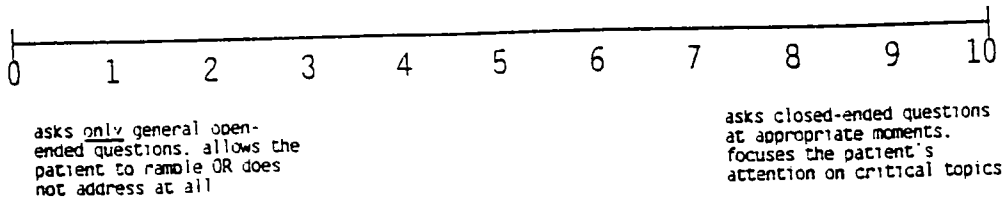
5. The physician directs the patient to <u>pursue</u> psychosocial topics.



This item is designed to assess the degree to which the physician uses a variety of skills to obtain the patient's psychosocial story. There are two components to this. One is directing the patient - keeping the patient focused on critical psychosocial topics. The other is actively seeking out additional information about those psychosocial issues.

[0-2] The physician provides no focus or direction for the interview, is extremely passive and allows the patient to wander from topic to topic. He/she ignores psychosocial data offered by the patient. (This category includes not addressing psychosocial topics at all.)

[3-5] The physician lets the patient talk about psychosocial issues but does not probe the patient for more information.

[5-7] The physician allows the patient to determine which, if any, psychosocial topics are discussed. The physician pursues these topics.

[8-10] The physician actively provides focus and direction for the interview. This includes seeking clarification and expansion of psychosocial data and the introduction of new and related concerns or issues.

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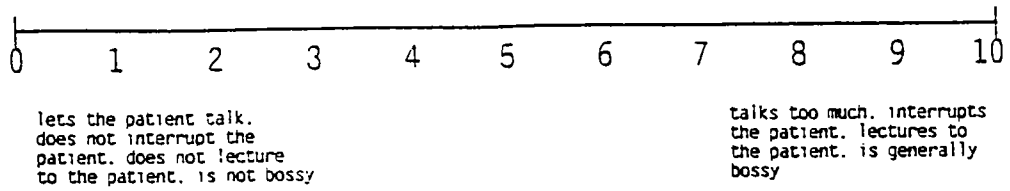
6. The physician dominates the interview.



This item is designed to assess the degree of control the physician maintains over the interview compared to the degree of control the patient has. It is important to note that maintaining control over the interview does not necessarily mean maintaining control over the patient. The physician who dominates the interview controls not just the direction of the interview but the degree to which the patient can participate in the interview. A physician who directs the interview while still allowing the patient to talk and participate is not dominating the interview.

[0-2] The physician allows the patient to direct the interview or to wander and ramble. The physician fails to provide direction when needed.

[3-5] The physician directs the interview in a functional way, but gives the patient a fair amount of control over the interview by allowing him/her to talk, introduce new topics, etc.

[5-7] The physician controls the interview in a functional way by keeping the patient focused on specific topics, using very directive, closed-ended questions, etc. The physician maintains more control over the interview.

[8-10] The physician controls the interview in a dysfunctional way by interrupting the patient, taking sole responsibility for the introduction of new topics, etc. and not allowing the patient to participate.

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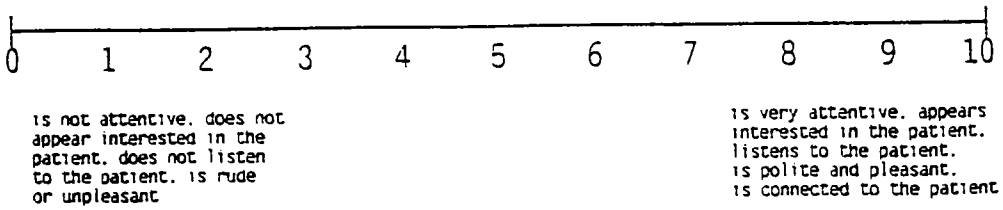
7. The physician has good rapport with the patient.



This item is designed to assess the quality of the emergent relationship between the physician and patient. Having good rapport goes beyond being pleasant and polite. It also includes a sense of connectedness.

[0-2] The patient and physician appear to dislike each other. Their relationship is adversarial, confrontational, etc. The physician is rude, unpleasant, cold, etc.

[3-5] The physician seems disinterested in and indifferent to the patient OR the physician is interested in the patient but has an adversarial relationship with him/her (e.g. the noncompliant patient).

[5-7] The physician is attentive to and interested in the patient but maintains some emotional distance from him/her. The physician maintains some detachment from the patient.

[8-10] The physician shows a genuine and sincere interest in the patient and is involved in his/her concerns. There is a sense of connection between the physician and the patient.

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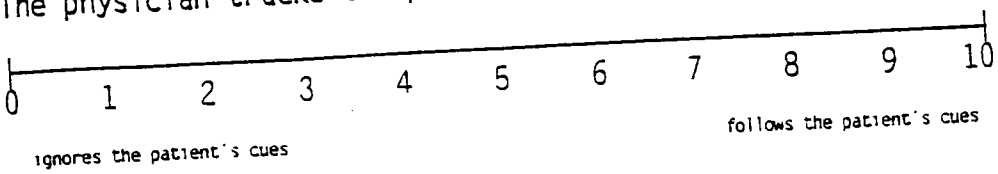
8. The physician tracks the patient.



This item is designed to assess the degree to which the physician follows the patient's cues, both biomedical and psychosocial. Tracking is fairly immediate, and it is an active process. The use of active facilitator (e.g. "Tell me more about...") is often a clue that the physician is tracking the patient. This item can be thought of as similar to item 3, responding to emotions. In this item, however, we are dealing with all patient cues, not just those expressing emotions. The more cues that are ignored or missed, the lower the score. Similarly, the more blatant an ignored or missed cue, the lower the score.

[0-2] The physician ignores or fails to pick up on patient cues or follow the patient's lead, even when the cues are quite clear.

[3-5] The physician follows some of the patient's cues but ignores or fails to pick up on most of them.

[5-7] The physician follows most of the patient's cues but ignores or fails to pick on a few more subtle cues.

[7-10] The physician follows the patient's cues, both biomedical and psychosocial. The physician detects and follows subtle cues if present.

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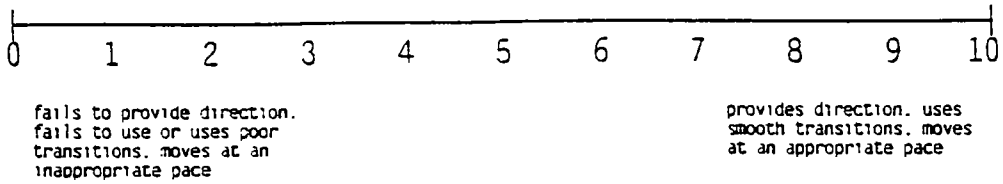
9. The physician manages the flow of the interview.



This item is designed to assess the physician's ability to conduct a smooth and coherent interview. Managing involves maintaining an appropriate direction and pace during the interview.

[0-2] The interview has no continuity or direction; it is hard to follow. The physician does not maintain an appropriate pace (e.g rapid-fire questions that rush the patient, letting the interview drag, allowing long, awkward pauses).

[3-5] The physician conducts an interview that can be followed, but jumps from topic to topic or allows the patient to jump from topic to topic.

[5-7] The physician provides direction and focus for the interview, but does not provide clear transitions between topics. The interview is coherent and orderly but does not flow as smoothly as it could.

[8-10] The physician provides direction for the interview and keeps the patient focused on the topic. The physician keeps the interview moving at an appropriate pace. The physician provides clear transitions between topics, and the interview flows smoothly.

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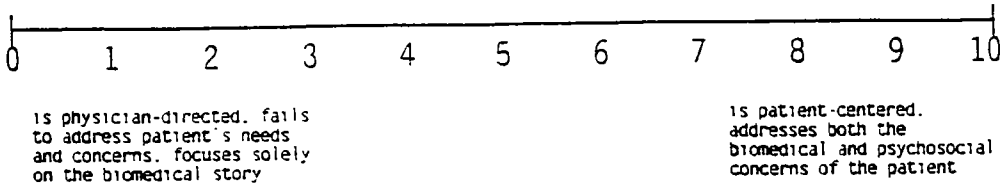
10. The physician conducts a patient-centered interview.



This item is designed to assess the extent to which the physician makes the patient's needs and concerns, both biomedical and psychosocial, the top priority of the interview.

[0-2] The interview is conducted solely on the physician's terms. The patient's needs are determined by the physician, the physician does not allow the patient to participate in setting the agenda or directing the interview. The physician is guided solely by his/her own goals (getting the biomedical story) and ignores or resists all patient cues or attempts to direct the interview.

[3-5] The physician acknowledges the patient's biomedical cues but does not acknowledge or pursue the psychosocial domain.

[5-7] The physician addresses both biomedical and psychosocial issues with the patient, but predominately pursues biomedical issues.

[8-10] The physician addresses the patient's needs, both biomedical and psychosocial, as defined by the patient. The physician acknowledges the patient's cues and actively pursues them.

NOTE: In cases where the physician acknowledges and pursues biomedical topics and does not pursue psychosocial topics when no psychosocial cues are present, assign a value of 5.

11. The physician/nurse practitioner effectively informs the patient that there is no organic disease.

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This item is designed to assess the extent to which the physician/nurse practitioner informs the patient of a nonorganic diagnosis in a sensitive manner, with appropiate explanation.

[0-2] The provider tells patient nothing has been found and offers additional tests/consultations OR provider tells the patient that there is no organic disease, but offers little additional information. Does not name medical problem; may say that treatment is outside medical domain; e.g., the patient needs psychiatric help. May indicate problem not life-threatening, but offers little or no hope for improvement. Uses jargon.

[3-5] May tell the patient diagnosis in terms of "good news"--nothing serious going on. May indicate no need for further tests, but conveys attitude that the patient is just going to have to live with it. Provider is upbeat but still fails to state that symptoms are *real*, or to give a medical label for symptoms.

[5-7] States diagnosis in terms of "good news" -- not life threatening. Gives symptoms a name and states problem is *real*. Explains can work on improving symptoms. Is upbeat in presentation.

[8-10] Gives diagnosis in terms of "good news" and expresses total confidence in diagnosis of no organic disease. Explains no cure, can improve well-being and control symptoms. States problem is *real* and gives a medical label to symptoms (IBS, migraines, fibromyalgia). Explains no more tests or surgery or consults are necessary. Checks patient understanding.

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13. The physician/nurse practitioner expresses willingness to work with the patient on a treatment plan.

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This item is designed to assess the degree of patient participation and commitment to treatment that is fostered by the provider as well as the thoroughness with which elements of the treatment plan are negotiated.

[0-2] Fails to talk about working together. Does not ask for patient opinion/input. No negotiation; very prescriptive in treatment approach. May express willingness to refer patient to other providers, or conduct more tests. No long-term plan offered.

[3-5] Talks about working on patient symptoms, but without patient input. Mentions treatment approaches and initiates implementation. May mention treating depression without explaining relationship to symptoms. Patient is not engaged in discussion; provider controls interaction.

[5-7] Provider engages patient more in discussion. Talks about treatment plan and gives patients a few options. May suggest seeing patient frequently, but doesn't specify schedule. Does not involve family in treatment plans. Fails to elicit a general commitment for treatment.

[8-10] Provider explicitly tells patient he/she wants to work with patient on problems. Asks what patient would like to work on first--solicits input and explores factors that will increase chances of success. Provider and patient determine goals for next appointment and up a specific schedule. Provider also gets a commitment from patient to adhere to the schedule, work together on the problems, and agree to no further testing. The provider involves the family in the treatment plan.

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14. The physician/nurse practitioner effectively enhances the patient's understanding of nonorganic causes of his/her symptoms.

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This item is designed to assess the provider's effectiveness at explaining the mind-body connection in a way that makes sense to the patient.

[0-2] No explanation of mind-body connection given. Provider insensitive--may say symptoms are "all in your head, and we need to get you off Valium."

[3-5] Provider acknowledges stressors but implies all psychological--does not validate symptoms or explain the connection between stress and symptoms.

[5-7] Provider acknowledges stressors. May give an example of how the mind and body work together, but does not individualize it to the patient psychosocial context.

[8-10] Provider explains mind-body connection with an explicit example (embarrassment causes blushing) and then further explains the connection between the patient's psychosocial context and his/her symptoms. Provider states symptoms are real--gives medical explanation and medical label. Explains that stress and depression are central to physical symptoms. Checks patient understanding.

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47. **uses open-ended questions early in the interview**

This involves asking at least two open-ended questions in the first few minutes of the interview.

DR: What brings you in today? PT: I have a sore throat? DR: Tell me more about that.	NOT	DR: What brings you in today? PT: I have a sore throat. DR: How long has your throat been sore?

It does not count if there are specific follow-up questions then the physician goes back to being open-ended. For example.

DR: What brings you in today?
PT: I have a sore throat.
DR: How long has your throat been sore?
PT: A couple days.
DR: Have you taken anything for it?
PT: Just some throat lozenges.
DR: Tell me more about how you've been feeling.

It does count if the physician tries to be open-ended and the patient does not take the opportunity to talk and the physician then becomes more directive. For example.

DR: What brings you in today?
PT: I have a sore throat?
DR: Tell me more about that.
PT: Like what?
DR: Well, how long has it been sore?

48. **uses neutral utterances**

This item focuses on neutral utterances (e.g. um-hmm, OK, uh-huh) that indicate the patient should continue talking. For example.

PT: I've been having a lot of pain in my lower back. DR: Um-hmm. PT: It feels really stiff when I get up in the morning.	NOT	PT: Is it OK for me to keep taking the Seldane while I use this nasal spray? DR: Um-hmm. That's fine.

49. **uses reflections or echoing**

Reflection/echoing involves repeating something the patient has said with the intention of eliciting more information. Repeating something the patient has said for the purpose of clarification is not echoing.

50. **uses open-ended requests**

An open-ended request grammatically takes the form of a command; it is a statement, not a question. It is used to encourage the patient to continue talking. This item is intended to determine if physicians used this specific technique, not to assess how open-ended they are in general.

These are open-ended requests: "Tell me more about that."
"Go on."
"Describe the pain to me."

58. **uses a transition from the psychosocial portion to the biomedical portion of the interview**

This is an explicit transition specifically from the psychosocial to the biomedical portion of the interview (the order can be reversed). This does not include more general transitions from one topic to another.

59. **tracks topics**

This involves tracking any topics - biomedical or psychosocial. This item is meant to determine if the physician tracks at all, not how well. If the physician tracks some topics but not others, he/she should still get a "yes." The quality of the physician's tracking is assessed in item 8.

60. **summarizes patient comments**

This can be a summary at the conclusion of the interview or it can be internal summaries used throughout the interview. This is a summary of the patient's comments, not a summary of what the physician has told the patient. For example,

"So, you have had the sore throat for about a week, aspirin helps the pain but the pain has been getting worse, and now it is starting to keep you awake at night? Is that right?"	NOT	"So, I want you to gargle with warm salt water twice a day, continue to take aspirin for the pain, and take these antibiotics four times a day for the next ten days."