

PSYCHOSOCIAL TEACHING
B339 Clinical Center
Michigan State University
East Lansing, MI 48824

GENERAL INFORMATION

Psychosocial Teaching
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Michigan State University
E. Lansing, MI 48824-1315

PSYCHOSOCIAL ROTATION ORIENTATION

This rotation is designed to provide you with a foundation in the psychosocial principles of medicine, with particular reference to their application in primary care. The attached reading packet serves as the textbook for this rotation.

Your packet contains the following:

General Information

The first section begins with your proposed schedule for the next four weeks. It is comprised of interviewing, seminars, and patient rounds with the teaching faculty. During this period, except to attend the indicated conferences, your time and effort can be devoted entirely to this rotation. You will need to continue to be available to handle problems that arise with your patients.

Also included for your consideration in the first section are learning objectives derived from the input of earlier learners. You should have received previously a letter explaining learning agreements, along with blank learning agreement forms. In that letter we asked you to begin formulating your own objectives that you would like to work on during the month. Please continue to update your objectives throughout the month on the forms provided. We also recommend that you keep a personal journal of your experiences during this rotation. Journal guidelines and blank sheets of paper are contained in a separate section to help you toward that end.

You will be given verbal feedback on all your work as you progress through the objectives on your learning agreement. However, because of the personal nature of the work done on this rotation, no grade is given. Provided there is active participation, everyone will receive the same rating (superior). In addition, given the personal nature of many of the discussions, all sessions are considered strictly confidential.

Seminars

Seminar readings are contained in two separate sections: one for Drs. Smith and Marshall labeled psychosocial seminars; and one for Dr. Osborn, labeled consultation-liaison seminars. You will be responsible for leading the seminar discussions which will be based upon the reading material. Session by session objectives and assigned readings are provided for the Smith and Marshall seminars. Be sure to review these objectives prior to every seminar. Following the seminar materials is an appendix which contains miscellany that may be helpful to you: a representative community calendar from the Lansing State Journal, a list of words that describe feelings, and a roster of those who have completed the psychosocial rotation in past years.

An audiotape recorder is provided for you and will be required for many of our interviewing instruction sessions. Over the course of the month, you will be required to tape record 10 to 12 interviews with patients. These recordings are reviewed during the interview critique sessions indicated on the schedule. Be sure to bring the recorder and taped interviews with you to each interview

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session. You will need to obtain patients prior to the interviewing sessions. You can get patients from your resident and faculty colleagues (either outpatient or inpatient). Talk briefly with the patient to obtain his/her written approval for both interviewing and taping the session; consent forms are in your packet. Explain that his/her participation aids you in your work on communication skills and that the interview is entirely confidential. Additional forms are available from Judi Lyles (administrator, psychosocial teaching research project, B-339 Clinical Center). Please verbally record the interview number for each interview on the tape before beginning an interview; i.e., "This is interview number one (two, three, etc)."

There is no need to find patients with psychological difficulties; any patient who is willing will suffice. When you schedule patients in the clinic for these interviews, be sure to notify clinic personnel. In addition to the interviewing work with Drs. Smith, Marshall, and Shebroe, it is recommended that you audiotape at least one patient daily for your own review and self-critique. Although time has been allotted throughout the week for you to conduct patient interviews, it may be occasionally necessary to interview patients during evening hours.

You will also have the experience of making patient rounds with the teaching faculty each day. Dr. Shebroe will round with you Monday mornings; Dr. Osborn on Wednesday mornings; and Dr. Smith on Tuesday, Thursday, and Friday afternoons.

We are looking forward to working with you and sharing ideas. Please contact Dr. Smith (5-6516), Dr. Marshall (3-8120) or Judi Lyles (6-2289) if you have questions or problems.

Psychosocial Medicine Rotation Schedule
 August 30, 1993 to September 26, 1993

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY
7:45-8:30 Morning Report	8:15-9:15 Grand Rounds	8:30-11:30 Osborn Seminar/ Rounds (Room 119 IMC)	9:00-11:30 Marshall Seminar (B-337 CC)	9:00-11:00 Smith Tape Review (B-337 CC)
9:00-11:00 Shebroe Continuity Rounds (Room 119 IMC)	9:15-12noon Marshall Seminar (Room 119 IMC)	Osborn continued	Marshall continued	Smith continued
1:00-5:00 RESIDENT CLINICS	1:00-3:00 Taping	12:00-2:30 Family Practice Conference (IM-Taping)	12:30-3:30 Taping	12:00-1:30 Internal Medicine Conference (FP-Taping)
	3:00-5:00 Smith Continuity Rounds (IMC)	3:00-5:00 Shebroe Tape Review (STL)	3:30-5:30 Smith Continuity Rounds (IMC)	2:30-5:00 Smith Continuity Rounds (IMC)

Please note: On Tuesday, September 21, the 9:15 seminar with Dr. Marshall will meet in the President's Room at Ingham Medical Center.

Objectives prepared by: Robert C. Smith, Alicia Marshall,
Valerie Shebroe, Gerald Osborn, Judith Lyles (July, 1991)

PSYCHOSOCIAL ROTATION OBJECTIVES

- I. The resident should exhibit the following specific data gathering and interactive skills during the first 15 minutes of an interview with a new patient:
 - A. Opening the Interview
 1. Know and use the patient's name, introduce self, welcome the patient
 2. Put the patient at ease and ensure comfort and a sense of privacy
 3. Overcome or acknowledge any barriers to communication (e.g., physical barriers, language difficulties)
 4. Determine the patient's understanding of the interaction (e.g., clarify if for teaching purposes, consultation)
 5. Jointly establish an agenda for the interaction with the patient (i.e., indicate time available and plan for its use)
 - B. Conducting the Patient-centered Portion of the Interview - Nondirective Dimension
 1. Begin with an open-ended statement (e.g., "How are things?" or "You're new here")
 2. Observe nonverbal data such as gestures, facial expressions, and style of dress
 3. Use open-ended responses (e.g., silence, nonverbal facilitation's, neutral utterances) in initial portion of interview (e.g., 30 seconds to 1 minute) to facilitate the free flow of information
 4. Use more active open-ended responses (e.g., reflection, requests, summaries) to maintain a free flow of information
 5. Avoid behaviors that may prematurely interrupt the free flow of information
 - a. exploring physician-centered hypotheses
 - b. using inappropriate interruptions
 - c. changing the topic of conversation
 6. Use closed-ended questions to clarify

- C. Conducting the Patient-centered Portion of the Interview - Directive Dimension
1. Use open-ended statements to direct the flow of information in a specific direction
 2. While data relevant to organic disease may arise, avoid specific physician-centered inquiry about possible organic disease diagnoses. Instead,
 - a. determine what the patient was doing when the symptoms occurred
 - b. determine what else was going on in the patient's life at the onset of the symptoms
 3. Identify and pursue key clues to the patient's personal story
 - a. listen for personal statements, and understand that the following are of progressively increasing importance
 1. statements unrelated to the present situation or to the interviewer
 2. statements about the interviewer or to the here and now
 3. statements about emotions
 4. nonverbal expressions of emotions
 5. behavioral expressions of emotions
 - b. actively elicit and address patients' expressions of emotions
 1. use nonverbal cues exhibited by the patient to anticipate emotions
 2. use direct inquiries about emotional response, especially to difficult situations when no emotion is expressed
 3. allow the patient to express affect
 4. use emotion handling techniques to facilitate the exploration of the emotion (refer to II.A. below)
 4. Develop the Patient's Personal Story through Hypothesis Testing
 - a. attend to affect with an open-ended comment or an emotion handling response
 - b. follow-up on additional personal data for further clarification and elaboration
 - c. refocus patient's attention on already developed personal/emotional references if the patient attempts to redirect the conversation
 - d. check with the patient for understanding of the personal story by summarizing key data

D. Making the Transition to the Physician-centered Portion of the Interview

1. Indicate the need to change directions and move on to the physician-centered portion of the interview
2. Determine if the patient has the need to discuss anything else before moving on

II. The resident should effectively use the following emotion handling/relationship building skills during the first 15 minutes of an interview with a new patient:

A. Use Emotion Handling Skills (N.U.R.S.)

1. Use statements that label and acknowledge the patient's feelings (Naming)
2. Legitimize the presence and expression of the emotion (Understanding)
3. Indicate respect and/or praise for the patient's efforts to manage the situation and emotion (Respecting)
4. Communicate support to the patient indicating assistance in dealing with the current situation (Supporting)

B. Exhibit Characteristics and Conducive to a Positive Physician/Patient Relationship

1. Empathy
2. Concern
3. Genuineness
4. Unconditional positive regard
5. Sensitivity
6. Providing information
7. Warmth
8. Supportive behaviors
9. Confidence
10. Active involvement
11. Self-disclosure

C. Develop Self Awareness of Previously Unrecognized Feelings (Countertransference) such as:

1. Fear of being unpleasant
2. Fear of losing control
3. Fear of involvement
4. Fear of criticism
5. Sexual excitement
6. Anger

- D. Develop Self Awareness of Behaviors Frequently Associated with Countertransference such as:
1. Being overly pleasing to the patient
 2. Being overly controlling of the interaction or of the patient
 3. Appearing detached, distant, or unconcerned
 4. Appearing judgmental or disapproving
 5. Behaving in a seductive manner

III. The resident should be able to determine and summarize the following information after an interview with a new patient:

- A. Personal Story
1. Relevant psychosocial data
 2. Patient's belief of the cause, course, and prognosis (meaning of symptoms) of illness
 3. Effect of the illness on the patient (interpersonally, professionally, socially, emotionally)
- B. Organic Disease Information
- C. Psychiatric Diagnosis (if applicable)
1. DSM III-R, Axis I & II
 2. Mental Status
- D. Personality Style
1. Indicators of dependent, obsessive-compulsive, histrionic, or self-defeating styles, whether qualifying for a psychiatric diagnosis or not

IV. The resident should be able to diagnose and manage most of the following patients in a medical setting

- A. Somatizing patients
- B. Depressed and anxious patients
- C. Substance abuse
- D. Loss; Grieving
- E. Adjustment disorders
- F. Psychological changes associated with organic disease
- G. Sexual/relational difficulties
- H. Negative health habits

- I. Developmental difficulties (childhood, adolescence, adult maturation, or aging)
- J. Parent-child difficulties
- K. Organic mental syndromes
- L. Noncooperative/noncompliant patients
- M. Stress

V. The resident should be aware of available community and psychiatric resources and be able to make appropriate referrals

VI. The resident should understand the basic psychopharmacology of antidepressants, anxiolytics, and drug detoxification

VII. The resident should be able to inform and motivate a patient to modify his/her behavior

A. Inform the patient

1. Check the patient's initial understanding of the behavior to be changed (including beliefs and attitudes about the problem), why the health behavior changes are necessary, and what actions the patient has taken in the past
2. Instruct/educate the patient on the specific behaviors desired from the patient, and the reasons for changing the health behavior
3. Summarize in general what the patient needs to do (e.g., stop smoking)

B. Obtain a commitment from the patient

1. Assess the patient's readiness to make a commitment to this desired behavior), avoiding pushing the patient not yet ready to alter behaviors
2. Provide reinforcement for related efforts to date
3. Encourage the patient to verbally commit him/herself to a specific course of action
4. Recognize this as potentially stressful and thus employ emotion handling skills

C. Negotiate and tailor the regimen to the patient

1. Evaluate and take into account the patient's lifestyle and circumstances particularly in terms of patient skills, resources, and support (both financial and emotional)
2. Encourage active patient participation
3. Discuss various behavioral alternatives, stating the most relevant or desirable first, using short sentences, avoiding technical jargon
4. Negotiate a mutually acceptable contract -- be willing to compromise and recognize that 1-2 steps may be sufficient initially
5. Once reached, repeat the agreement, often both in writing as well as verbally
6. Check the patient's comprehension of the contract by having him/her repeat it
7. Establish follow-up procedures and expectations, and reaffirm the negotiated plan

D. Attend to the patient's emotional responses

1. Use emotion handling techniques (N.U.R.S.)
2. Express concern for the patient
3. Communicate a sense of empathy for the patient
4. Reinforce the patient's past and present efforts

E. Exhibit personal skills and characteristics conducive to change and motivation

1. Use modeling/authority techniques
2. Use attribution of competency
3. Use conditioning techniques
4. Use rehearsal of intent

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PSYCHOSOCIAL SEMINARS

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PSYCHOSOCIAL ROTATION - SESSIONS OVERVIEW

WEEK 1

SEMINARS 1 & 2: USING A PATIENT CENTERED APPROACH TO ELICIT
THE PATIENT'S STORY

Objectives:

- A. To understand how patient-centered interviewing differs from physician-centered interviewing
- B. To understand how and why using a patient-centered approach relates to potential outcomes (e.g., patient compliance, patient satisfaction) and the reliability of data gathered
- C. To be able to differentiate between open-ended and closed ended questions, between the patient-centered and the physician-centered portion of the interview, and between the directive and nondirective dimensions of the interview
- D. To rehearse the model for a patient-centered data gathering interview
- E. To understand emotion seeking and emotion handling skills (N.U.R.S.)

Readings:

Smith, R.C. The Patient's Story: Integrated Patient-Doctor Interviewing. Boston: Little, Brown & Co. (Now Lippincott-Raven); 1996; Chapters 1-3.

Handouts of the patient-centered interviewing model

Targeted Rotation Objectives: I, IIA

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WEEK 2

SEMINARS 4 & 5: DIAGNOSING AND MANAGING A SOMATIZING PATIENT

Objectives:

- A. To understand the general patient education model of interviewing
- B. To be able to identify the various distinguishing characteristics and "symptoms" that lead to suspecting somatization disorder
- C. To understand the process of diagnosing a somatizing patient through ruling out organic disease
- D. To examine and rehearse various techniques for informing somatizing patients of the potential of a non-organic basis for their illness
- E. To examine techniques for negotiating a treatment plan with somatizing patients

Readings:

Smith, R.C. Somatization Disorder: Defining its Role in Clinical Medicine. Journal of General Internal Medicine. 1991;6:168-175.

Informing and Managing the Somatizing Patient (2 page handout)

Targeted Rotation Objectives: IVA

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SEMINAR 3: INTERACTING EFFECTIVELY WITH VARIOUS PERSONALITY
STYLES & DEVELOPING SELF-AWARENESS OF RESPONSES TO
VARIOUS PERSONALITIES

Objectives:

- A. To be able to identify key distinguishing characteristics of four primary personality styles (dependent, obsessive-compulsive, histrionic, self-defeating)
- B. To be able to identify and demonstrate appropriate interaction management techniques depending on the patient personality style
- C. To be able to identify personal personality characteristics
- D. To begin to develop a self awareness of previously unrecognized responses (countertransference) and signs of personal discomfort during patient encounters

Readings:

Smith, R.C. The Patient's Story: Integrated Patient-Doctor Interviewing. Boston: Little, Brown & Co. (Now Lippincott-Raven); 1996; Chapter 7.

Targeted Rotation Objectives: IIC, III

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WEEK 3

SEMINARS 6 & 7: EDUCATING AND MOTIVATING THE PATIENT

Objectives:

- A. To understand and rehearse techniques for providing information to the patient concerning the undesirable health behavior
- B. To understand and rehearse techniques for obtaining commitment from the patient to a specific course of action
- C. To rehearse techniques for managing patients unwilling to commit to a specific course of action
- D. To understand and rehearse techniques for negotiating and tailoring a health care regimen with the patient
- E. To understand the nature and importance of patient behavior contracts

Readings:

Smith, R.C. The Patient's Story: Integrated Patient-Doctor Interviewing. Boston: Little, Brown & Co. (Now Lippincott-Raven); 1996; Chapter 9.

Informing and Motivating Patients (2 page handout)

Information from the American Cancer Society and American Heart Association

Targeted Objectives: VII

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WEEK 4

SEMINARS 8 & 9: DELIVERING BAD NEWS & MANAGING DIFFICULT
SITUATIONS

Objectives:

- A. To develop strategies for effectively and empathically delivering bad news to patients and/or their families
- B. To examine strategies for discussing and negotiating DNR status with patients and patients' families
- C. To understand what patients view as supportive and unsupportive from physicians

Reading:

- Quill, T.E. & Townsend, P. Bad News: Delivery, dialogue and dilemmas. Archives of Internal Medicine. 1991;151:463-468.
- Smith, R.C. The Patient's Story: Integrated Patient-Doctor Interviewing. Boston: Little, Brown & Co. (Now Lippincott-Raven); 1996; Chapter 9.

PATIENT-CENTERED INTERVIEWING MODEL

COMPLETE INTERVIEW:

[-----I-----]	PT CNT (10%)	PHYS CNT (90%)
	-pt directed	-physician directed
	-predominantly psychosoc data	-predominantly biomedical data
	-some biomed data	-often some additional psychosoc data uncovered
	-reliance on open ended question	-reliance on closed ended questions
	-focus on obtaining contextual info	-focus on obtaining history of present illness, past med history, family history...(recognize much of this may emerge during pt-cnt)

PATIENT CENTERED PORTION OF THE INTERVIEW:

[----I----I-----I-----I----]	STAGE A.S.	NON-DIRECTIVE	DIRECTIVE	TRAN-SITION
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Setting the Stage (STAGE): opening the interaction by introducing self, establishing patient comfort, and engaging in "small talk"

*reduces patient's nervousness

Agenda Setting (A.S.): establishing with the patient the issues to be covered during the interview

ex: "We have about 15 minutes today and before we get started I want to make sure we both know what we're going to try to accomplish. What exactly brings you in today? ... Anything else before we get started?"

- *facilitates obtaining patient's complete list of needs
- *helps establish boundaries
- *gives the patient sense of control over appointment

Nondirective Phase: allowing the patient to proceed anywhere without direction or focus from physician

ex: "so how are things going?" (rely on open ended questions as an opening statement/remark)

- *provides an overview in the patient's own words
- *indicates physician's willingness to listen
- *enhances the physician-patient relationship

Directive Phase: focusing the patient on subjects the interviewer believes to be important, either already raised by the patient or not (typically focusing on psychosocial data)

ex: "tell me more about feeling nervous that you're in the hospital..."

- NOTES:
- 1.rely on open-ended questions and facilitating comments
 - 2.seek out psychosocial data/emotional reactions
 - 3.actively use emotion handling skills (NURS)

- *develops important story details not readily revealed
- *allows physician to structure/guide interview to be more time efficient

Transition: smoothly moving from Phase 1 (the patient-centered portion of the interview) to Phase 2 (the traditional physician-centered portion of the interview)

ex: "It sounds like a lot has gone on in your life recently with you moving to a new city and starting a new job. We need to shift gears a bit now if you are feeling finished...Let me ask you a few specific questions about your backaches..."

- NOTES:
- 1.summarize the patient's story/what you've heard
 - 2.give the patient the opportunity to give you any additional information
 - 3.preview the shift in focus to biomedical/phys cnt

- *communicates to the patient the physician has been listening
- *warns the patient of the shift from patient control to physician control
- *provides a sense of closure if "difficult" issues have been discussed

PSYCHOSOCIAL ROTATION
Informing & Managing Somatizing Patients

INFORMING THE PATIENT

1. Present the diagnosis as "good news" & "bad news"
ex. - we know exactly what it is, but I'm afraid it's a chronic problem that we're not going to be able to cure
2. Provide a "face saving" biomedical explanation
3. Emphasize "care" not "cure"
ex. - this problem isn't going to go away, but we can move it aside so that you can go back to functioning more normally
4. Emphasize no need for surgery, further tests, or consulting any specialists
5. Reaffirm that this is NOT a life threatening disease
ex. - I know that you've been nervous about this being cancer. I want to assure you that there is definitely no tumor; this is NOT cancer.
6. Acknowledge/reinforce that the problem is real - the patient is not making the pain up.
7. Establish/explain the mind-body link (introduce the concept of stress)
8. Discuss the inevitable link to clinical depression
9. After informing the patient of the diagnosis, be sure to double check the patient's understand.
ex. - I know I've thrown a lot of information at you, why don't you tell me what you've heard me say.
10. Throughout the interaction:
 - * use emotion handling skills (watch out for nervousness, disappointment, depression)
 - * reassure the patient you'll be working together, you won't be abandoning them
 - * be confident & definitive

GAINING A COMMITMENT FROM THE PATIENT

1. Acknowledge that it will be hard work for the patient to learn to control the symptoms (it will involve some lifestyle changes)
2. Reaffirm that you will be working together on this
3. Ask specifically if the patient is willing to work with you to control the symptoms

MANAGING THE PATIENT

1. Start out by agenda setting
 - * ask the patient for his/her goals
 - ex. - what are some of the things you'd like to be able to do again that you haven't been able to?
 - * share with the patient your goals for him/her if they are any different
 - * jointly establish a set of BEHAVIORAL goals to work toward
2. Negotiate with the patient the specific treatment
 - * begin antidepressants if indicated
 - * taper pain meds or sedatives if currently being used
 - * increase physical activity/exercise/physical therapy if indicated
 - * instead of taking meds PRN, take them on a regular schedule regardless of symptoms
 - * make regular office visits regardless of symptoms
3. Set up frequent office visits
 - * discuss the behavioral goals each time - provide the patient with praise for those that have been met, discuss which goals to work toward next
 - * focus interaction during office visits on goals, functioning, and psychosocial issues - not on physical symptoms
 - * rely on emotion handling to pull out stressors facing the patient
 - * always make physical contact at each appointment (do a brief PE)

PSYCHOSOCIAL ROTATION
Informing and Motivating Patients

INFORMING THE PATIENT

1. Establish baseline understanding
2. Educate the patient on:
 - a. the harmful effects of the current behavior (e.g., smoking)
 - b. the positive effects of changing the current behavior

NOTE: begin this persuasive appeal based on personality characteristics/need of the particular patient

ex - Obsessive/compulsive: provide statistics
Histrionic: focus on effects on body image
Self-defeating: focus on the difficulty of changing, but benefit for others
Dependent: focus on your desire for patient to be healthy

3. Clearly & explicitly state the need to change - provide the patient with the "bottom line"
4. Check patient understanding of why change is necessary and what the desired behavior is

GAINING A COMMITMENT FROM THE PATIENT

1. Ask patient for a commitment to work toward change
2. Acknowledge that it will be hard work for the patient to change current behavior(s)
3. Reaffirm that you will be working together on this - minimize isolation
4. Emphasize that ultimately it is the patient's choice and responsibility
5. Ask the patient to verbalize his/her commitment to change

NOTE: be sure to gain this commitment BEFORE moving to the negotiation phase

NEGOTIATING WITH THE PATIENT

1. Establish a baselinge of specific behavior - how habit is reinforced, when behavior occurs, how often the behavior occurs...

NOTE: the more concrete the information, the more useful it will be.

ex -- when negotiating with a high cholesterol patient, determine exactly what the patient eats each meal, how much they eat, what activities they engage in a typical week...

2. Negotiate a specific plan - remembering that many undesirable behaviors may need to be changed one step at a time

3. Have the patient repeat the specifics of the plan once agreed upon

4. Reinforce commitment

General Recommendations:

1. Use emotion handling throughout - remember changing these behaviors will be very stressful, anxiety provoking

2. Use self disclosure if appropriate

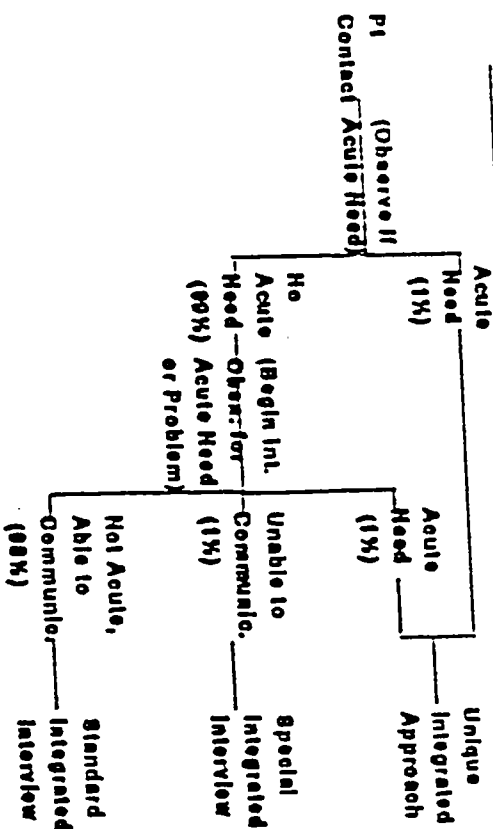
3. Reinforce hope above all else

4. Encourage as much patient involvement and participation as possible - the more active a patient is, the more likely he/she is to comply with the plan

5. If the patient is unwilling to commit initially:

- a. Check why the patient doesn't want to change
- b. Provide additional information if necessary
- c. Indicate you are not rejecting the patient
- d. Ask "what would it take to change your mind"
- e. Keep your foot in the door - discuss at next visit

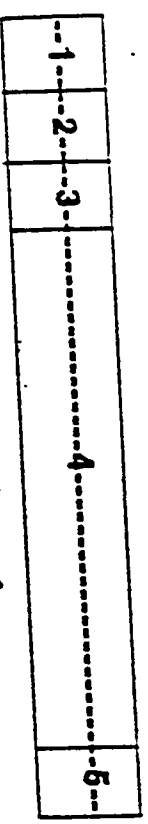
INTEGRATED PATIENT-DOCTOR APPROACH... ALL PATIENTS



ALGORITHM FOR INITIALLY DETERMINING WHICH IS BEST APPROACH FOR INDIVIDUAL PATIENTS

1

PATIENT-CENTERED HPI



Five Key Steps

- 1 - Setting the Stage
- 2 - Agenda Setting/Chief Complaint
- 3 - Nondirective Interviewing
- 4 - Directive Interviewing -- Focus on Personal
- 5 - Transition Into Doctor-Centered HPI

• Basic components of PTC Operational Model

STANDARD INTEGRATED INTERVIEW

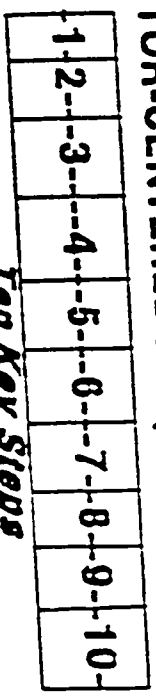
PTC 10 %	DC 80 %	PX 10 %
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[CC-----HPI-----PMH, FH, SH, ROS] +

PTC (Patient-centered) DC (Doctor-centered)
 Patient's agenda Physician's agenda
 OE, EH > CE Inquiry CE > OE > EH Inquiry
 PS > BM data BM > PS data

BIOPSYCHOSOCIAL STORY

DOCTOR-CENTERED HPI (AND REMAINDER)



Ten Key Steps

- 1 - Focus on organic disease data
- 2 - Overview of all problems and symptoms
- 3 - Specifics for Problem #1 (most urgent)
- 4, 5 - Specifics for additional problems
- 6 - past Medical History
- 7, 8, 9 - Noncurrent issues: Social History (7), Family History (8), Review of Systems (9)
- 10 - Summary and Transition (into PX)

REFERENCES

1. Spiegel D. Social Support: How Friends, Family, and Groups Can Help. In: Goleman D, Gurin J, eds. *Mind/Body Medicine*. Consumer Reports. New York; 1993:331-349.
2. Kabat-Zinn J. Mindfulness Meditation: Health Benefits of an Ancient Buddhist Practice. In: Goleman D, Gurin J, eds. *Mind/Body Medicine*. Consumer Reports. New York; 1993:259-275.
3. Kiecolt-Glaser J, Glaser R. Psychoneuroimmunology and Health Consequences: Data and Shared Mechanisms. *Psychosomatic Medicine*. 1995; 57:269-274.
4. Benowitz NL. Treating Tobacco Addiction - Nicotine or No Nicotine? *New England Journal of Medicine*. 1997; 337:1230-1231.
5. Hurt RD, Sachs DP, et al. A Comparison of Sustained-Release Bupropion and Placebo For Smoking Cessation. *New Eng J of Med*. 1997; 337:1195-1202.
6. Stoffelmayr B, Hoppe RB, Weber N. Facilitating Patient Participation: The Doctor-Patient Encounter. *Primary Care*. 1989; 16:265-278.
7. Jacobs JW, Bernard M, et al. Screening for Organic Mental Syndromes in the Medically Ill. *Annals of Internal Medicine*. 1977; 86:40-46.
8. Gerson S, Bassuk E. Psychiatric Emergencies. An Overview. *The American Journal of Psychiatry*. 1980; 137:1-11.
9. Viscott D. Understanding People. Taking Care of Business. Wm Morrow & Co. 1985: 50-70.
10. Blair SN, Kohl HW, et al. Physical Fitness and All-Cause Mortality: A Prospective Study of Healthy Men and Women. *Jama*. 1989; 262:2395-2401.
11. Drugs That Cause Psychiatric Symptoms. *The Medical Letter*. 1993; 35:65-70.
12. Quill T. Partnerships in Patient Care: A Contractual Approach. *Annals of Internal Medicine*. 1983; 98:228-234.
13. Berkman LF. The Role of Social Relations in Health Promotion. *Psychosomatic Medicine*. 1995; 57:245-254.
14. Lipowski ZJ. Physical Illness, The Individual and the Coping Processes. *Psychiatry in Medicine*. 1970; 1:91-102.
15. Smith RC. *The Patient's Story: Integrated Patient-Doctor Interviewing*. Boston: Little, Brown & Co. (Now Lippincott-Raven); 1996:Chapters 1-3, 7, 9.
16. Smith RC. Somatization Disorder: Defining its Role in Clinical Medicine. *Journal of General Internal Medicine*. 1991; 6:168-175.
17. Quill TE, Townsend P. Bad News: Delivery, dialogue an dilemmas. *Archives of Internal Medicine*. 1991; 151:463-468.