Current Trends in the Educational Approach for Teaching Interviewing Skills to Medical Students

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Abstract

Research in the acquisition of patient interviewing skills by medical students has dealt mostly with the evaluation of the effectiveness of various teaching programs and techniques. The educational approaches (i.e., the tutor-learner relationship and learning atmosphere) have rarely been discussed. These approaches may be grouped into: a) "teacher-centered" (didactic), in which the students are passive recipients of instruction; b) "learner-centered," in which the tutor functions as a facilitator of small group learning, whose task is not to teach but rather to ensure that all students participate in the discussions and share knowledge with other students; and c) "integrated learner-and teacher-centered" or "experiential learning," which consists of an ongoing dialogue between the tutor and the students. In this paper, we review the strengths and weaknesses of these educational approaches and attempt to identify the current trends in their use in the teaching of interviewing skills. It would appear that until the 1960s, medical students acquired interviewing skills without any expert guidance. On the other hand, since the 1970s, there has been a tendency to offer and upgrade undergraduate programs aimed at imparting communication skills to medical students. Initially, these programs were didactic; however, during the last decade, there has been an increasing shift to teaching interviewing skills by promoting experiential learning.

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It is generally agreed that patient interviewing is an important clinical skill. Its main objectives are not only to collect disease-related data that would eventually lead to a diagnosis, but also to gain an insight into the patients' concerns [1], establish mutual trust and cooperation with patients [2], respond to patients' need for information [3], and assess patients' preferences for involvement with their care [4]. Since the 1970s, medical schools have offered teaching programs aimed at achieving these objectives [5-8]. These programs have consisted of various combinations of lectures, workshops, supervised encounters with real and simulated patients, and viewing and discussing videotaped doctor-patient encounters. During the 1990s, the proportion of time occupied by teaching interviewing skills out of the total undergraduate curriculum has varied markedly at various British [9] and Israeli medical schools [10].

Until now, research into the pedagogy of patient-interviewing skills has focused on the techniques aimed at imparting these skills and on the evaluation of the effectiveness of these techniques [7]. However, the educational approaches to teaching interviewing skills have been rarely discussed. The term "educational approach," as used here, refers to the learning atmosphere in general and to the tutor-learner relationship in particular. In this paper, we attempt to identify the strengths and weaknesses of the various educational approaches and the current trends in their application in teaching programs of patient interviewing.

The recognition that medical students need help in learning how to communicate with patients is a recent development in medical education. As late as the 1960s, most medical students graduated without ever interviewing a patient under expert supervision.

Approaches to teaching

Educational approaches may be viewed as a continuum between a teacher-centered, or didactic, approach [11] at the one extreme and a learner-centered approach [12] at the other, with a combination of these two approaches in between, referred to as an integrated learner- and teacher-centered or experiential approach [13,14].

The teacher-centered (didactic) approach

A teacher-centered approach casts the teacher in the role of the person who determines the learning objectives at the outset of curriculum planning and how the subject would be taught. The students are passive recipients of knowledge, which is commonly imparted by lectures, and of skills, which are taught by exposure to role models. The teacher-centered approach only rarely considers the learner's opinions. Successful achievement

of learning objectives is assessed by observation and written and oral tests. In the case of interviewing skills, a strict teacher-centered program would describe the teacher's views on correct and incorrect ways of communicating with patients.

The main appeal of the teacher-centered approach is its common sense: the teacher knows the subject matter, while the students do not, and therefore, it is the teacher who should be in charge. However, this approach may increase the students' dependence on the teacher and reduce their ability for critical thinking and for using other sources of information. Furthermore, a teacher-centered approach does not seem to be the most effective teaching tool. The average student maintains concentration during lectures for only 15 minutes [15], and this approach appears to be ineffective in changing established behavior patterns [16].

The learner-centered approach

At the other extreme, learner-centered programs encourage self-directed small group learning through sharing of knowledge among the participants. Such programs cast the tutor as a facilitator of learning, whose task is not to teach but rather to ensure that all the students participate in discussions and share knowledge with other students in the group. The premise of strict learner-centered programs is that tutors do not necessarily need content knowledge so long as they are skilled in the tutoring process, and even if they do possess such knowledge they should refrain from sharing it with the students [17].

The main feature of learner-centered programs is the students' freedom and responsibility to direct their own learning. The advantage of such programs is that they promote teamwork, critical reasoning and self-directed learning. In the case of interviewing skills, a strict learner-centered approach would encourage the students to discuss among themselves their own experience in communicating with other people and in observing doctors' interactions with patients, and to decide upon an optimal approach to patient interviewing.

Neither the strict teacher-centered nor the strict learner-centered approaches seems to be appropriate for achieving the objectives of a teaching program of patient-interviewing skills. On the one hand, students have been reported to feel uncomfortable with a teacher-centered approach to teaching patient interviewing [18,19]. On the other hand, it is unreasonable to ask students to re-discover by themselves, without any expert guidance, the skills of patient interviewing using a strict learner-centered approach. It seems that these weaknesses of both approaches have led to the adoption of the ILTC approach, which would provide guidance on the subject to be learned, as in a teacher-centered approach, while still allowing students to build on their prior knowledge and share it with other students, as in a learner-centered approach.\

The integrated learner- and teacher centered (experiential) approach

Similar to a teacher-centered strategy, an ILTC approach is guided by defined learning objectives. The tutor attempts to achieve these objectives by providing students with information, demonstrating to them relevant skills and supervising them as they exercise these skills. Similar to a learner-centered strategy, an ILTC tutor would avoid adopting an authoritarian attitude toward the students, while encouraging them to construct their own knowledge through group discussions and self-directed learning. He or she is expected to facilitate such discussions, gain an insight into what the learners already know about the subject to be learned and help them build on this knowledge.

Unlike the teacher-centered approach, which consists of lecturing with minimal student participation, and unlike the learner-centered approach, which is restricted to self-directed learning with minimal tutor's intervention, the ILTC approach encourages an ongoing dialogue between the tutor and the students. Unlike the tutors of strict learner-centered programs, who are expected to only facilitate the small-group discussions, ILTC tutors are expected to possess mastery of subject matter knowledge as well as the ability to communicate with students in an informal way, coupled with an empathic attitude that encourages an open exchange of ideas. This combination involves facilitation and coaching of individualized learning.

The main advantage of the ILTC approach is that it is consistent with adult learning theory. Adults are motivated by learning that builds on the learner's previous experience and requires the learner to reflect on his/her behavior [13]. An ILTC approach to teaching is also the one most consistent with the current views of the learning process known as constructivism. Constructivism states that knowledge is "constructed" by the learner by contrasting one's own understanding of a problem with that of others, and that learning occurs when students assimilate new knowledge into a preexisting conceptual framework within a defined context [20].

Furthermore, an ILTC approach appears to be more effective than a strict learner-centered approach. Comparative studies of small groups guided by tutor-facilitators with no subject matter expertise (i.e., using a strict learner-centered approach) and by tutors who are both subject matter specialists and facilitators (i.e., using an ILTC approach) have indicated that the latter tended to take a more directive role in tutorials, in the sense that they spoke more often and for longer periods, provided more direct answers to the students' questions, and suggested more topics for discussion [21]. There is evidence suggesting that students guided by subject matter experts spent more time on self-directed study, and achieved better on examinations than did the students guided by non-expert tutors [21-23].

The integrated learner and teacher-centered approach for teaching interviewing skills

In the case of teaching interviewing skills, an ILTC approach would assume that students: a) have already formed their communication habits with other people, and that they will benefit from opportunities to reflect on these habits; b) possess personal views about patients' expectations from doctors, and can identify deficiencies in doctors' communication with patients; and c) can suggest ways that doctors can use to overcome these deficiencies. The tutor-student dialogue would consist of discussions of

ILTC = integrated learner- and teacher-centered

the students' preconceived views about communication skills, the objectives of the patient interview and the best ways to achieve them. Similar to teacher-centered strategies, it is the task of an ILTC tutor to provide students with information, demonstrate to them communication skills, supervise them as they exercise these skills until they acquire competence, and still avoid an authoritarian approach. Similar to learner-centered strategies, the ILTC approach would encourage students to build on their previous experience with communication skills.

To apply an ILTC approach to teaching interviewing skills, tutors should not only be experienced clinicians, they should also have additional training in those aspects of the behavioral sciences that pertain to patient interviewing [24] and in facilitating small group learning [25]. The tutors should also be confident enough in their own skills to demonstrate to a group of medical students a live, not videotaped, interview, of a real, not simulated or standardized, patient, because live demonstrations seem to command the students' attention more than videotaped or standardized doctor-patient encounters which often appear to lack credibility [26]. The use of simulated or standardized patients would be restricted to supervised student practice whenever interviews with real patients are not feasible.

Since the 1970s, most medical schools offer programs teaching communication skills to medical students. Initially, these programs were didactic but in the last two decades have shifted to teaching interviewing skills through an experiential approach, which includes a dialogue between tutor and learner, reciprocal learning and feedback to the learner

Even though there is wide agreement on the objectives of patient interviewing, students may encounter considerable variability in the communication styles of their preclinical instructors and role models during the clinical clerkships [27]. Some of them use a "disease-centered style," which emphasizes the need for the doctor to collect disease-related data; other tutors define the objective of communication with patients as providing "patient-centered care," i.e., one allowing physicians to negotiate management decisions with patients, while showing respect for their autonomy. Indeed, during the 1990s, medical students in Israel [26] and the UK [19] were reported to be perplexed by the contradiction between the patient-centered communication style that was taught in the preclinical courses of patient interviewing, and the disease-centered communication style that students observed during the clinical clerkships.

One of the objectives of the ILTC educational approach is to address the variability of opinions regarding patient interviewing and to discuss the advantages and disadvantages of the two communication styles. Rather than teaching the students that there is a single right way to communicate with patients, the tutor would encourage students to define the problems that may arise during doctor-patient encounters, figure out possible solutions, and discuss their advantages and disadvantages in an atmosphere characterized by critical reflection on, and respect for, the worth of the different solutions, and student empowerment to make their own choices. By presenting the two communication styles as legitimate, and by encouraging the students to consider the trade-off between their advantages and disadvantages and choose the style that they view as being most appropriate in the clinical situation that they are encountering, the ILTC approach also reduces the students' confusion produced by the conflicting interviewing styles of their pre-clinical and clinical tutors and among their role models. It uses these conflicting messages as an opportunity for further exploration and learning, rather than allowing it to be a cause of perplexity.

Trends in the educational approaches for teaching patient interviewing skills

Until the 1960s, communication between doctors and patients was regarded as a simple task and not worthy of being taught. Medical students were left to their own devices, and most of them graduated without ever interviewing a patient while being supervised by an experienced clinician [28]. Since the 1970s, most medical schools have introduced teaching programs of patient interviewing. During the 1980s and the 1990s, many, if not most of these programs were teacher-centered. At two medical schools in Israel (Hebrew University of Jerusalem and Ben-Gurion University in Beer Sheva), with which one of the authors (J.B.) was affiliated in the 1980s and 1990s, teaching of patient interviewing during the pre-clinical years included introductory, teacher-centered lectures. Similarly, surveys conducted in the 1990s at UK medical schools indicated that most interviewing skills programs were teacher-centered [29] and ignored students' attitudes and opinions about patient interviewing [30]. In many cases, such lectures were apparently ineffective: UK medical students have complained that "they had no conceptual understanding of the purpose of taking a history" [18]. Some of them even complained that the didactic teaching of interviewing skills during ward rounds was humiliating, and that they would value a more egalitarian teaching environment where their own observations were respected [18].

However, more recently, several authors [8,26,31,32] have described teaching programs on doctor-patient communication that consist of the ongoing teacher-learner dialogue that characterizes the ILTC approach. It has been suggested that teaching patient interviewing skills should begin with the tutor's understanding of what students notice in their clinical surroundings, what they need, and how their perspectives differ from those of the tutor and of practicing physicians [33]. These programs have included individual tutoring [34], teaching approaches that were centered on the learner's agenda [32], and 'Balint groups', i.e., discussions of feelings, unwittingly harbored by the doctor toward his or her patient that may interfere with the doctor's approach to the patient and confound the doctor's judgment [35]. Other programs

have used the evidence of current deficiencies in doctor-patient communication as a point of departure for small group discussions [8,26]. The most common categories of patient complaints about physician behavior in the USA have been reported to be disrespect, disagreement about expectations of care, inadequate information or misinformation, and it has been suggested that these categories be used in developing curricula related to communication skills [36]. Still other authors [37] have emphasized that the student-patient communication is primarily shaped by the student-tutor relationship, and have used the PEARLS mnemonic (**p**artnership, **e**mpathy, **a**pology for, **r**espect, **l**egitimation, **s**upport) to describe the common features of the desirable atmosphere of the tutor-learner and doctor-patient relations [37].

In conclusion, it would appear that teaching of patient interviewing is gradually moving from the traditional teacher-centered (didactic) programs to an ILTC (experiential) approach, the essential features of which include a dialogue between tutor and learner, learning that is relevant for the clinical skill to be learned, feedback to the learner and reciprocal learning [38]. In this paper, we have discussed the logic and characteristics of this latter approach. Future research may compare its effectiveness with that of the traditional teacher-centered programs in terms of student performance and satisfaction.

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