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Developing therapeutic interview skills in medical students

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There has been considerable interest in doctors' interviewing skills during the last few decades (Nuffield Working Party, 1978). Despite this interest, there has been no consensus as to how these skills may be taught to medical students. We describe the ongoing evolution of a teaching package for these skills as taught by the Liverpool University Department of Psychiatry.

The aims of such a package were to develop basic psychotherapeutic skills in the general student that would not only make the process of psychotherapy interesting and intelligible, but also sow the seed that these skills, if generalised, could enhance all fields of medical practice. The skills would therefore be developed to be used in a continuum from the undergraduate to postgraduate trainee. Undergraduate interview skills have been described by Maguire and others (Maguire *et al*, 1984). Past teaching methods used by the Liverpool school for medical students have involved didactic descriptions of such skills (Cox *et al*, 1981), progressing to workshops with interactive videos based on the Conversational Model of psychotherapy (Margison & Hobson, 1983). The later teaching models have incorporated selected elements of the *Grammar of Psychotherapy* (Liebermann & Cobb, 1987).

The Liverpool package

The University Department teaches the package over the course of a single day, some five times a year. Thirty-five final year medical students attend and are taught by three psychiatrists during the day. The large group meets in a circle to discuss specific skills such as open questions and the use of pauses to facilitate an interview. Liebermann & Cobb's first interactogram forms the basis for a useful checklist of 13 such skill behaviours. Either a role play or a video of a consultation is enacted before the large group to demonstrate these skills being used by a doctor.

The large group breaks down into groups of three or four students. The trio is given a cassette recorder so they can record and monitor their own interview behaviour. The individuals in each group become alternately the doctor, the patient and an observer. The observer records the interaction on tape and also on the skills checklist. The 'patient' in the role play focuses on a real or imagined loss. Loss is used since it is a significant recurring experience encountered in medical practice. Any life event could involve some loss and students might be given examples that they may have experienced themselves, for example failure at exams or job interviews.

Sample tapes can be examined in the large group later. After each member of the group has been both a patient and a therapist we make a specific attempt to challenge existing interview skills (often including an over-use of the closed question) and create new ones. In one exercise the therapist is asked to respond only after deliberately waiting for three seconds before making his intervention. This helps the groups explore the advantages and disadvantages of a pause for the patient, who may find it either encouraging or intimidating. Another prescribed exercise involves the psychiatrists running the group prohibiting the 'doctor' in the role play from using questions at all. Only statements may be used. In this way medical students can see alternatives, as on a menu, to their usual means of conducting interviews.

In the afternoon we focus on the intent of verbal interventions by the doctor. What did the doctor want to achieve when he said something and how effective was that intervention? We have adapted Liebermann & Cobb's second interactogram for this purpose and on this second list consider whether interventions on a taped interview are designed to seek or give information, confront, catalyse, or support. The large group splits down again into small role play groups to explore this model.

The final part of the day concerns how these skills might be used in psychiatry, say to enhance empathy or encourage catharsis, or be generalised into other fields of medicine, say in breaking bad news or trying to make sense of a patient's anger. We discuss how such interviews might, with consent, be recorded for self or peer supervision.

Comment

The Liverpool package is popular among final year students and we hope before long to evaluate objectively whether it can persistently improve doctors ability to pick up patients' cues and to deal intelligently with patients' emotions.

The Conversational Model and the Grammar of Psychotherapy were developed with psychiatric trainees in mind and, although they are forerunners of this Liverpool course, the final form of our package for medical students has yet to crystallise. Our aim is to create a consistent approach through all levels of training, so that undergraduate interview skills reflect our postgraduate psychotherapy approach (Luborsky, 1984). The introduction for student doctors and beginner postgraduate trainees should be basic, relatively theory-free and concentrate on rapport. Later, as required, it can be supplemented by specific skills training for family, behavioural, and psychodynamic therapy.

We hope to extend undergraduate teaching in interviewing skills considerably, with teaching components accompanying each relevant stage of clinical training, so that student doctors can be enabled to cope with the sometimes overwhelming emotions generated by clinical work.

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People and places

Scottish Action on Dementia: a new response to an old problem

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Scottish Action on Dementia had its origins in informal meetings of individuals drawn from a variety of health care professions with a shared concern about the inadequacies of provision for dementia sufferers in Scotland in the mid 1980s. At the heart of these concerns lay the absence of any effective response to two major documents – the Timbury Report and SHAPE (Scottish Hospital Authorities Plans for the Eighties). Both accorded the highest priority to care of the elderly, particularly those suffering from mental illness, and had been accepted by all the principal parties concerned as the blueprint for health care policies in Scotland in the 1980s. The sober realities of 1985 prompted the founding members of Scottish Action on Dementia (SAD) to set themselves up as a multidisciplinary forum with three principal functions – to promote public education and awareness of dementia and its implications for sufferers, families and society at large; to act as an independent pressure group; and to monitor activities in the field of dementia care with a view to promoting and maintaining high standards. Five years later these objectives remain unchanged.

Membership of the organisation has risen to some 300 individual members made up of both health care professionals and concerned citizens. The president