The Impact of Patient-Centered Narrative Interviewing on the Perceptions of Primary Care Clinicians: a Pilot Evaluation

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The Impact of Patient-Centered Narrative Interviewing

on the Perceptions of Primary Care Clinicians: a Pilot Evaluation

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# Table of Contents

**Abstract**  
4

**Section I: Clinical Problem**  
Problems with a Clinician-Centered Approach  
Problems with a Patient-Centered Approach  
Identifying the Essential Elements of Patient-Centered Interviewing  
Making the Personal Transformation Required to Practice  
Patient-Centered Interviewing  
6

**Section II: Clinical Solution**  
Components of Evidence-Based Patient-Centered Interviewing  
Skills Used Simultaneously  
Rapport Building and the Relationship Maintenance  
Mindful Practice  
Topic Tracking  
Acknowledging Social or Emotional Clues with Empathy  
Skills Used Sequentially  
Up-front, Collaborative Agenda Setting  
Exploring the Patient’s Perspective  
Co-creating a Plan  
Patient-Centered Interviewing in a Narrative Mode  
History and Basic Concepts  
Application in Patient-Centered Interviewing Skills  
Rapport Building and the Relationship Maintenance  
Mindful Practice  
Topic Tracking  
Acknowledging Social or Emotional Clues with Empathy  
Up-front, Collaborative Agenda Setting  
Exploring the Patient’s Perspective  
Co-creating a Plan  
14

**Section III: Project Implementation**  
Purpose  
Rationale and Assumptions  
Overall Design and Objectives  
Outcomes Evaluated  
Setting  
Training Approach and Method  
Intervention and Data Collection  
26

**Section IV: Project Evaluation**  
Results  
Participant Characteristics  
Outcomes  
PCC Perceptions of Patient’s Condition, Diagnosis and Treatment Plans  
Value of Information Provided to PCC  
PCC Frustration  
Differences between Clinician and Interviewer Assessments of Patient Problems  
35

Analysis  
Participants and Sites  
Outcomes  
36

41
PCC PERCEPTIONS OF PATIENT’S CONDITION, DIAGNOSIS AND TREATMENT PLANS 42
VALUE OF INFORMATION PROVIDED TO PCC 43
PCC FRUSTRATION 44
DIFFERENCES BETWEEN CLINICIAN AND INTERVIEWER ASSESSMENTS OF PATIENT 44
PROBLEMS 44
DISCUSSION 44

SECTION V: NEXT STEPS 47

SECTION VI: IMPLICATIONS FOR ADVANCED PRACTICE NURSING 54
CONCURRENCE WITH NURSING THEORY 55
CONCURRENCE WITH DNP COMPETENCIES 57

REFERENCES 64

APPENDICES
ILLUSTRATIONS AND GRAPHS 68
FORMS/TOOLS USED IN STUDY 76
IRB DOCUMENTS 83
To restore the human subject at the centre . . . we must deepen a case history to a narrative or tale; only then do we have a ‘who’ as well as a ‘what’, a real person, a patient, in relation to disease.

- Dr. Oliver Sacks, *The Man Who Mistook His Wife For a Hat*

**Abstract**

In this project, psychiatric nurses were trained in patient-centered narrative interviewing approaches and placed in a variety of healthcare sites and conditions to function as consultants. Primary care clinicians (PCCs) in those sites selected patients that each clinician felt was frustrating or difficult and arranged for the consultant to interview them. The consultants then presented patient information to the PCC, data typically difficult to obtain using a standard medical interviewing format. The consultant and PCC discussed the new information provided. The PCC than determined if the information provided was valuable, whether it changed their clinical decision-making regarding this patient’s diagnosis and treatment, if their previous level of frustration was improved as a result, and shared other impressions regarding the information or the process.

The purpose of this paper is to first discuss the problem of a clinician-centered approach and the larger context of health care system transformation. Next, the nature of patient-centered interviewing is presented. Then, the project’s methodology, implementation, and findings, as a small test of change, are provided. Finally, the lessons learned and implications for advanced practice nursing are offered.

PCCs in this project reported altering their perceptions after consultations with the nurses. As a result of information provided from the interviews, clinicians reported modifications in their patients’ diagnoses and treatments. This form of interviewing also reduced clinicians’
self-reports of frustrations and provided them with information they portrayed to be extremely valuable.

The PCCs in this study listed changes they planned to make in their patients’ diagnosis and/or treatment plans, and they reported confidence in those decisions and selected a timeframe in which they would take that action. However, it is not known whether any of those clinicians actually followed through on those reports, nor is it known whether outcomes were improved as no chart review was performed in this project.

As a result of participating in this project, it is hoped that PCCs will consider adding a psychiatric mental health nurse practitioner as a consultant to their primary care team in order to continue this service. Or, a PCC may choose to undertake training in patient-centered narrative interviewing as a part of the personal transformation needed to successfully employ a biopsychosocial approach in their practice.
Section I: Clinical Problem
Problems with a Clinician-Centered Approach

Over this past year in legislative halls and at kitchen tables, Americans debated the problems of our country’s current health care system. Yet these problems are not new. Nearly a decade ago the prestigious Institute of Medicine (IOM) envisioned nothing less than a transformation of the entire health care system. The IOM characterized the current approach to healthcare as clinician-centered when compared to the new desired patient-centered approach. In the current approach, professional autonomy drives variability and professionals control care. In the new approach, care needs to be customized according to patient needs and values, and the patient is the source of control.

In its first monograph, *To Err is Human* (Committee on Quality of Health Care in America, 2001b), the IOM indicted the American healthcare system as a major cause of morbidity and mortality. In its follow-up report, *Crossing the Quality Chasm* (Committee on Quality of Health Care in America, 2001a), sweeping changes to the way care is delivered in this country were proposed. The IOM’s approach focused on structural and functional solutions and stated six aims for the 21st century health care system. The new health care system needs to be safe, effective, timely, efficient, equitable; and must be become patient-centered rather than clinician-centered.

Problems with a Patient-Centered Approach

This patient-centered approach, however, is not new. Its roots can be found in the biopsychosocial model that has had a profound influence on many health care clinicians since the 1970s (Herman, 2005; Weston, 2005). What is novel currently are the widespread attempts to adapt and implement this approach nationally. Two problems have surfaced from these attempts. First, identifying and characterizing the specific clinician behaviors of this approach was difficult and practices were inconsistent and variable. The second, and thornier problem was the personal
transformation required of the individual physician in order to engage in these practices.

**Identifying the Essential Elements of Patient-Centered Interviewing**

Projects and literature reviews have been conducted to provide evidence-based approaches to the practice of patient-centered interviewing. A Cochrane review of interventions to promote a patient-centered approach in clinical consultations was initially conducted in 1999 and updated in 2009. The goal of this review was to assess the effectiveness of interventions that were designed to promote health care clinicians’ use of patient-centered approaches in their patient consultations. The studies selected trained healthcare clinicians as an element of the intervention, and the clinicians were mainly primary care physicians. Patient-centered care was defined as:

“A philosophy of care that encourages: (a) shared control of the consultation, decisions about interventions or management of the health problems with the patient, and/or (b) a focus in the consultation on the patient as a whole person who has individual preferences situated within social contexts (in contrast to a focus in the consultation on a body part or disease)” (Lewin, Skea, Entwistle, Zwarenstein, & Dick, 2001).

This review found fairly strong evidence that training in patient-centeredness for healthcare clinicians may improve communication with patients, enable clarification of patients’ concerns, and improve satisfaction with care (Lewin, Skea, Entwistle, Zwarenstein, & Dick, 2001).

A literature review by Lewin, Skea, Entwistle, Zwarenstein, & Dick, (2001) did find that patient-centered interviewing produced improvements in health outcomes, and included reduced psychological distress, reduced physical limitations, improved functional status, increased medication compliance, and increased satisfaction from both patients and clinicians.

The Kalamazoo consensus (1999), arose from a comprehensive approach to deliberate and five models of communication. Twenty-one leaders and representatives from major medical
education and professional organizations met in Kalamazoo, Michigan in 1999. Effective communication in a clinical setting included approaches to open the discussion with a patient, to gather information, to understand the patient’s perspective, to share information, to reach agreement on problems and plans, and to provide closure. However, the group highlighted the more fundamental necessity for physicians to build relationships with their patients. That undertaking was the foundation upon which the other tasks were built (Makoul, 2001).

More recently, Mauksch and colleagues conducted a literature review examining studies that combined relationship development, communication skills, and time management (Mauksch, Dugdale, Dodson, & Epstein, 2008). Employing these skills, the studies show, should enable clinicians to communicate effectively in a time-efficient manner while simultaneously building a relationship with patients. These skills include the following: rapport building/relationship maintenance, topic tracking, acknowledging social/emotional clues with empathy, up-front collaborative agenda setting, exploring the patient’s perspective, and co-creating a plan (Mauksch, Dugdale, Dodson, & Epstein, 2008).

As a result of these efforts, there are several elements required in patient-centered interviewing. What becomes more difficult is to define the personal transformation required of the individual physician in order to engage in relationship-building.

**Making the Personal Transformation Required to Practice Patient-Centered Interviewing**

Although patient-centered interviewing is a key component in the new models of health care on a national scale, the personal transformation required of individual physicians to achieve patient-centered interviewing has proven difficult and elusive. There is little direct research available on this topic. However, studies on uncertainly, ambiguity tolerance and physician personalities help to better understand this transformation.
The IOM established the Committee on the Future of Primary Care to address the growing concern and frustration among family physicians over front line work situations that had come to be known as “hamster medicine” (i.e., running on a spinning wheel without getting anywhere). The cornerstone of this new model of family medicine practice was to be whole-person and patient-centered care. They envisioned a fully participatory culture existing within each family medicine setting (Martin, et al., 2004).

This new model of family medicine identified in that report helped initiate national conversations leading to the concept of a patient-centered medical home (PCMH). In 2006, the national demonstration project (NDP) was undertaken by the American Academy of Family Physicians in order to evaluate this new model. Thirty-six family practices were chosen from among 337 and were evaluated over a two-year period. The report concluded that a transformation to a PCMH is a developmental process and clearly warned that the level of transformation needed much more than new sophisticated office systems. They pointed out that a fundamental shift of this nature would challenge physicians’ personal identities. This personal transformation of physicians would require relationship-centered partnerships that went far beyond adherence to clinical guidelines (Nutting, et al., 2009).

Given the achievements of medical science in the treatment of disease, another type of transformation has been underway at the same time as the patient-centered care movement. Research-based, or evidence-based medicine has become the gold standard. In practice, this positivistic, biomedical perspective is essentially a doctor-centered approach. Clinical decision-making requires the collection of data from the patient’s symptoms, exam findings, lab tests and other assessments. The individual patient’s illness, as the story of suffering or disease as
experienced by that person, is not data in the biomedical perspective. Physicians are disinclined to spend time listening to patients’ stories given the exigencies of increasingly complex cases and burdened schedules. Yet discourse and communication is the key to the patient-centered approaches (Bensing, 2000; Weiner, 2004).

What is it about this transformation that makes it so challenging and difficult for physicians? Much more is required than the basic interpersonal and communication skills that every medical school graduate has since 2004 been trained in and required to demonstrate on the U.S. Medical Licensing Examination (USMLE) Clinical Skills Examination (Rider & Keefer, 2006).

Patient-centered interviewing is a rebirth of the biopsychosocial model. Practitioners of this approach attest that applied biopsychosocial science is not easily taught. In addition, it is often difficult to determine under which conditions it should be employed. Thus many physicians find it appealing, but difficult to implement. Cues that patients present to physicians may be difficult to attend to and to sort out. In an attempt to understand the patient’s experience of illness as much as the pathology of the disease, physicians must genuinely value relationships and dialogue in addition to data collection. Practitioners must not only demonstrate competency in the basic interpersonal and communication skills; but be more psychologically-minded in order to successfully employ the biopsychosocial approach (Herman, 2005; Weston, 2005).

Given the growing realization that practicing in a manner consistent with the biopsychosocial model may not even be possible in the current medical environment, transitional, or split models have been proposed. This split biopsychosocial model lets physicians focus primarily on the biomedical aspects of a case unless psychological and social factors are clearly important. However, it is unclear when and how a physician would even know if or when
to switch gears during patient interviews if only subtle cues presented (Weston, 2005).

Other clues about the difficulty making the personal transformation required for patient-centered interviewing come from studies examining ambiguity and uncertainty. Considerable ambiguity already exists in relational aspects of clinical encounters. Cultural factors of illness expression and value bias in diagnosis frequently generate uncertainty. In a study evaluating medical students and faculty in a cultural diversity curriculum, teachers felt considerable pressure to provide facts regarding cultural diversity as students expressed discomfort with uncertainty. A push for facts reflects a certain disregard for subjectivity and an over reliance upon technology in medical education (Dogra, Giordano, & France, 2007).

To support this interpretation, Dogra and colleagues (2007) present studies of British medical school students who were administered tolerance for ambiguity tests during their training. Medical students interested in the organic aspects of illnesses are less tolerant of ambiguity than those students expressing interests in psychological and organic factors of disease. Male students are less tolerant of ambiguity than female students, and those with physical science undergraduate degrees are less tolerant than those with humanities or social sciences backgrounds.

Finally, two more studies demonstrated that British surgeons are less tolerant of ambiguity than general medicine physicians and this lower tolerance effected of their clinical decision-making. Physicians distressed by uncertainty are more likely to initiate some action than to sit with the ambiguity experienced in a patient encounter (McCulloch, Kaul, Wagstaff, & Wheatcroft, 2005; Tubbs, Elrod, & Flum, 2006).

In summary, the IOM indicted that the current healthcare system as clinician-centric and needed a major reorientation in order to become patient-centered. This major transformation
would require organizational and personal changes. However, the physician in the center and in charge still needed to do the work required on individual basis in order for the projects to be successful.

A Cochrane review found fairly strong evidence that training could actually increase patient-centered approaches (Lewin, et al., 2001), and another review demonstrated improved health outcomes from those approaches (Lyles, et al., 2001). The Kalamazoo consensus standardized and sequentially ordered the elements of patient centered interviewing. Finally, the relationship, communication, and efficiency model constructed an integration of the Kalamazoo elements and biopsychosocial practices needed to implement patient-centered approaches in a time-efficient manner (Mauksch, et al., 2008).
Section II: Clinical Solution
Components of Evidence-Based Patient-Centered Interviewing

There are two separate but equally important skill tracks required for patient-centered interviewing. One track contains skills that are used in a simultaneous manner while the other track contains skills used in a sequential manner. The skills in the simultaneous track find their origin in the biopsychosocial model, while the skills in the sequential track derive from the 1999 Kalamazoo consensus.

Skills Used Simultaneously

**Rapport building and the relationship maintenance.** Relationships are critical to the success of the patient-centered approach. A key piece in building a relationship is simply being present with the patient and demonstrating a willingness to accompany them on the journey. Healing relationships have an underlying structure according to research, and three key processes have emerged that foster relationships. First, create a nonjudgmental emotional bond. Second, manage power in ways that would most benefit the patient. Third, display a commitment to caring for patients over time. This relationship works to benefit both patient and clinician. The focus on relationships can be seen as a means to reinvest in meaning and service and thus humanize the healthcare environment for everyone involved (Scott, et al., 2008).

Because this model focuses on time efficiency, it focuses on building rapport, a more fundamental aspect of relationship maintenance. This can be accomplished by a simple statement such as, “Nice to see you. How is your garden this year?” Each visit starts with this brief check-in to reestablish the relationship. Other skills described here subsequently build on the trust established in this manner and help mature the relationship.

**Mindful practice.** This skill features the quality of being present to the patient in the frame of the interview space. It is a critical curiosity on the part of the clinician, who then
monitors his or her own thought processes in order to avoid dominating the agenda and forcing premature closure. The purpose is to avoid any waste of time focusing on issues that are not important to the patient. The practice of passionate engagement with the patient has its roots in the original purpose of mindfulness in Buddhism; to alleviate suffering and cultivate compassion (Ludwig & Kabat-Zinn, 2008). Just as in relationship building, mindful communication demonstrated an improvement in physicians’ well being, psychological distress, burnout, and capacity for relating to patients (Krasner, et al., 2009).

**Topic tracking.** The average patient typically presents with 3 to 6 concerns per visit. (Beasley, et al., 2004) Therefore, this skill requires an ability to identify and follow several important concerns. The sub skills critical to topic tracking include summarization, or sharing one’s impression of what has been discussed; process transparency, or describing the interaction; and goal alignment, or confirming the agreement on the focus of discussion. The practitioner monitors the discussion as if an outside observer; looking for course changes, uncompleted topics, and switching to other issues.

**Acknowledging social or emotional clues with empathy.** A clue is defined as a direct or indirect comment providing information about life circumstances or feelings. Clues provide practitioners with a view of the patient’s inner worlds and create opportunities for empathy and personal connections. A study of clues in primary care and surgical settings revealed that in over half of the visits patients provided clues, and the average number of clues provided was two to three. Social clues gave an opportunity to learn about the patient’s life but are not associated with an emotion. Emotional clues involve the implicit seeking of support and/or the expression of a feeling. Only 21% of the clues in a primary care setting received a physician response and these missed opportunities were tied to longer visits (Levinson, Gorawara-Bhat, & Lamb, 2000).
Another aspect of this skill, empathy, is the ability to understand the patient’s situation, perspective, and feelings and to communicate that understanding to the patient. Recognition and empathic acknowledgment of clues permits the patient to discuss their beliefs about the illness and preferences for treatment. An empathic response might be picking up on a suggestion or indication of concern, conflict or emotion with a phrase like, “Let’s see if I have this right,” or “Sounds like…” The practitioner then reflects the content back to the patient. Empathic connections require practitioners to sometimes delay responding; permitting long pauses before responding (Coulehan, et al., 2001).

**Skills Used Sequentially:**

**Up-front, collaborative agenda setting.** History-taking is the standard approach in the clinician-centered interview, but in the patient-centered interview, the goal is to collaboratively build a history with the patient rather than “taking” it. This necessitates a fundamental shift in the way practitioners engage with patients. One approach is to use conversational devices rather than questions, such as paraphrasing reflecting and directives (Haidet & Paterniti, 2003).

Agenda setting does not mean exploring extensively the very first topic that the patient presents. Rather, allow the patient to tell the story without interruption but in conjunction with topic tracking and acknowledging clues. In order to assure inclusion of as many patient agenda items as possible, a practitioner might use a phrase such as, “was there anything else you hoped to address today?” Or “something else?” Once the agenda items are clarified the practitioner might say, “What concerns would you like to address today?” Finally, the practitioner clarifies agreement on the priority agenda item or items by repeating them aloud to the patient.

In a study of unvoiced agenda items in general practice, one study found that agenda items not disclosed in the interview led to problem outcomes such as major misunderstandings,
unwanted prescriptions, or non-adherents to treatment. Common unvoiced agenda items included concerns about the future, patients’ ideas about what the problem is, side effects, not wanting a prescription, seeking information relating to social context, and other possible diagnoses. Just over 10% of patients in the study voiced all of their agenda items (Barry, Bradley, Britten, Stevenson, & Barber, 2000).

Exploring the patient’s perspective. Having clarified and prioritized the patient’s agenda items, the next step is to explore a patient’s current understanding of the condition and/or its management. This approach is interwoven with the diagnostic investigation. If patient and clinician differ on the ascribed cause, there is little chance they will agree on the prescribed treatment. These explorations may actually be accomplished without increasing visit length and may allay anxiety, improve adherence, and identify gaps in knowledge. This approach typically requires only 30 seconds to five minutes.

Co-creating a Plan. Once the agenda has been set, the conditions explored from both biomedical and psychosocial perspectives, patient and clinician must agree upon the next steps. In this last phase, it becomes clear whether or not the practitioner has adequately followed the skills listed in this section. Failure to follow clues, track topics, acknowledge agendas and elicit perspectives creates a misalignment and resistance. This skill may involve negotiation between patient and practitioner as well as the use of additional skill sets such as health behavior change practices and motivational interviewing.

These skills require practice and time if they are to become mature, consistently used, and meet the goals of building a relationship and improving communication in a manner efficient enough to be performed within the time limitations of a typical primary care visit. The goal is to
foster a more natural and integrative approach to accomplishing the basic elements of patient-centered interviewing described in this section.

**Patient-Centered Interviewing in a Narrative Mode:**

Employing a skill-based approach is not a sufficient method to help practitioners successfully make the shift, or personal transformation called for in the biopsychosocial model of clinical practice. Narrative-based approaches have been adopted in many fields, including clinical arenas, and appeared to offer a means to make the transition to a more authentic approach. The advantages offered by adding a narrative-based interviewing style to the patient-centered interviewing skill set will be examined.

**History and basic concepts.**

Narrative-based approaches employ certain narrative elements in order to better understand a human condition or situation. These narrative elements consist of specific aspects one might think about when hearing or reading a story (e.g., narrator, point of view, and plot, etc.). Analyzing these elements helps to understand the characteristics and concerns of those in the story, why s/he is telling you about this now, what significant events transpired, and what has happened or might happen next, and why all of this is so important (Herman, 2009). Various fields of study have further developed these basic narrative elements into a range of methodologies, or narrative approaches.

‘La narratologie’ was a term used in 1969 by the French structuralist school of literary criticism to describe a “science of narrative” (Herman, Jahn, & Ryan, 2005). Since then, la narratologie has taken root and expanded to numerous fields of inquiry. Many authors have labeled this phenomenon “the narrative turn.” Social and behavioral sciences developed narrative approaches to describe the inner experience over time of events in people’s lives. Narrative
approaches now underpin and inform fields as diverse as history, political science, anthropology, law, and psychology (Herman, 2003)

Cognitive scientists employ narrative approaches at the intersection of neuroscience, literary studies, and cognitive theory to better understand the mind’s operations. (Herman, Jahn, & Ryan, 2005). E. O. Wilson, Harvard professor and founder of the field of sociobiology, finds narrative approaches critical to an understanding of evolution itself (Gotschall & Wilson, 2005).

In the clinical sciences, clinicians undertake narrative approaches to understand the world from the patient’s point of view and to communicate and provide treatments within that context. Dr. Rita Charon (2006) coined the term “narrative medicine” to underscore her discovery that much of the practice of medicine was informed by narrative approaches.

“Narrative therapy” is a term used to describe a range of narrative practices used in counseling (White, 2000). Narrative therapy focuses on a person’s construction of who and where they are, how they got there, and where they think they are headed. The psychiatric diagnosis or disorder that might bring a client to therapy is seen in this context as a constraint and is not itself the focus of treatment. Family therapy and narrative therapy interventions have even been blended and then successfully adapted for use in busy primary care settings (Launer, 2002).

The methods used in each of these various clinical fields listed hold that the patient-clinician relationship forms the foundation to all other interactions. Another central concept is that the meaning of a patient’s illness and the context of any disease are central to case formulation and treatment planning, and the prerequisite to any successful application of an evidence-based practice. Practitioners of the narrative-based approaches view them as a way to balance the art with the science of health care (Charon, 2006; Launer, 2002; White, 2000).
A narrative-based style of interviewing is fundamentally a conversational device, or a form of asking that connects to the human need to tell their story and communicates in the same mode or level as a patient who is relating to events from a place of feeling threatened or fearful.

From a narrative perspective, the basic clinical situation is this: two people greet each other in a small closed room. One of them is distressed by something and has come with the expectation that the other person wants to know about it. A conversation ensues. The person in distress, or the teller, relates a set of events and circumstances along with the fears, hopes, meanings, and implications that go along with it. The listener tries to imagine the situation of the teller as he or she attempts to also follow the plot of the story.

The teller in distress, or the patient, is driven to story the event in a basic therapeutic need to get some shape and find some control over the chaos of their life in the wake of this disease or disorder. The practitioner’s basic narrative task is to facilitate telling however much of the story is possible. If he or she fails to perform this narrative task, the patient might not ask the most frightening questions and might not feel listened to. The rest of the workup might then be more extensive than it needs to be and the correct diagnosis might be missed (Charon, 2001).

As practitioners, we must not only facilitate this story-in-process and attempt with the patient to understand it, but we must also communicate the risks and the benefits of a particular treatment approach. This is the second narrative task, and it will require us to speak a language that is spoken by intuition rather than factual logic.

According to fuzzy-trace theory and recent research in cognitive science, the way people reason about risk differs from other approaches to reasoning (Reyna, 2004). Its process is highly automatic and takes place outside of conscious awareness. Conscious experience seems unitary and integrated because we have constructed a personal narrative about who we are and how
things happen (Roser & Gazzaniga, 2004). This narrative and its seamless nature are disrupted by the experience of the illness or traumatic event. The patient’s job now, with the practitioner’s help, is to effectively appraise risk and repair the disruption. Narrative is the lingua franca of this realm, not formal or scientific logic and the recitation of facts (Skott, 2001; Wissow, 2007).

Achieving competency in these two basic narrative tasks requires that clinicians develop the skills for both thinking about story and thinking with story (Jones, 2002). Thinking with story involves an inter-subjective experience; a space entered into by both patient and clinician. This space, or meeting place, entered into by teller (patient) and listener (clinician) places certain conditions on the patient-clinician relationship. A mutual respect is required. This is a special bond; the on-going responsibility and accountability over time that is expected when one receives the story of another (Carson, 2002).

Thinking about the story a patient brings to a practitioner involves closely reading and interpreting the story presented as one would a written text. What do you need to know in order to understand and to interpret the patient’s two journeys, the inner and the outer? This includes asking questions such as, who is the narrator and what is the point of view? We also need to ask what symbols and metaphors are used and what do they suggest about this experience? Then we need to find out why is s/he telling the story in this way? Would the telling be different with another audience?

Application in Patient-Centered Interviewing Skills

Rapport building and the relationship maintenance. In the previous section under this topic, establishing rapport was the primary goal in order to keep the time at a reasonable length. This is accomplished by a simple checking in statement at the beginning of the interview. The practice of all of the skills collectively helps in establishing a relationship. What a narrative-
based style adds is the even more fundamental and supportive value of relationship needed in an authentic dialogic engagement with another human being. It is the very comportment of the practitioner when eliciting the patient’s story that makes this difference. The object of dialogue in a narrative approach is more than the casual conversation, and in fact requires participants to suspend their opinions and engage the other with a kind of presence that is in response to an ethical call. It is the regard in which the practitioner holds the patient that makes this difference (Morris, 2002).

**Mindful practice.** Mindfulness in the narrative-based approach is achieved through self-reflection in practice. Practitioners need to make sense of their own life journeys, identify and interpret their own reactions to the suffering they encounter on a daily basis in providing care to others. This is accomplished through regular journaling and sharing the personal aspects of their professional experience with other practitioners. In the Narrative Medicine program at Columbia University, medical students create a “parallel chart” to record their daily experiences in order to present them to colleagues at regularly scheduled meetings (Charon, 2006). However, reflective journaling takes many forms and may be done through a blog, a collective wiki done with other students, or an online journal that is read only by the instructor. The goal of this reflective practice is authentic engagement with their patients, and an ability to nurture acceptance of human weakness and affirmation of human strength (Charon, 2001; Dunlap, 2006).

**Topic tracking.** Topic tracking in a narrative approach listens not only for symptoms and concerns, but for narrative elements found in the practice of thinking about story and in discourse analysis. Thinking about story in a topic tracking approach involves a close reading of a verbal account for elements of plot, such as identifying the ethical dilemma or moral crisis, the hero’s mission, direction, obstacles, and allies (Chanbers & Montgomery, 2002; Hawkins, 2002).
A frame in discourse analysis is recognizing what governs the interpretation of what the other person says. For example, a typical medical interview sets up a frame that is confusing. Does the patient understand their role? Do they know that what they say is interpreted by sifting through the words for symptoms and symptom characteristics? Or do they believe that the practitioner is there to help them organize their thoughts and feelings about the nature of their concerns? In the process of telling a story, patients choose their topics and what is permissible to reveal according to an ongoing process of reading their audience for clues. Discordant frames create tensions and misunderstandings and lead to omissions of important information (Ness & Kiesling, 2007).

**Acknowledging social or emotional clues with empathy.** For this skill, the narrative-based modification would be the addition of another category of clues; narrative clues. In the close reading approach of thinking about story, the practitioner listens for themes of meaning, semiotic trends, and other metaphors. What significant details were attached to each other in a pattern of meaning that makes sense of the whole? As the listener, what surprised you, or what did you expect to find and did not? What symbolic terms are used repeatedly? Are there parallels between the symbols used and the distressing situation? (Childress, 2002)

**Up-front, collaborative agenda setting.** It is important it is to build a history rather than take one. It is important therefore to start of with an approach that does not cause the patient to restrict the initial presentation, or telling of his or her story. An example of an opening question might be, “Tell me what you want me to know about you or what is bothering you.”

It was also suggested that the practitioner use conversational devices rather than direct questioning to get all of the patient’s agenda items disclosed for this visit. A narrative modification of the skill was adapted from family therapy. The overall purpose of a
Conversational method of questioning is to permit the patient to move from well-versed territory into new directions of understanding what is happening to them. Thus the purpose of the questioning is always looking for ideas that suggest possibilities of new understandings and a change. This technique is a conversation inviting change. In order to elicit agenda items while keeping open the possibility of change, the practitioner might explore differences and connections, hypothesize aloud to the patient, engage in circular questions aimed at narrowing down possibilities, strategizing or negotiating choices, and frequently reflecting their thoughts about this ongoing process to the patient (Launer, 2002).

**Exploring the patient’s perspective.** Exploring the patient’s perspective through narrative approaches incorporates the discourse analysis concepts of heuristics as well as some components of close reading skills employed when thinking about story. The heuristics of a conversation look at causality and cautions, including the meaning of what happened and beliefs or interpretations about why it happened, as well as beliefs related to how to stay safe (Ness & Kiesling, 2007).

The components from thinking about story include looking at who is the narrator of the story, the point of view, and the representation of self and identity. Does the teller feel he can initiate or change events? What are the roles the teller takes in the story, and what does he reveal about his purpose? What/who are the other identities comprising the self that should be considered as a result of this disruption? How does the narrator view others in this story? When the practitioner recounts aspects of the story back to the narrator, what is the reaction? (Jones, 2002)

**Co-creating a plan.** As a result of the agenda disclosing approach that initiated a conversation inviting change, and from the reflections, hypothesizing, and negotiations involved
in that process; what are the various options for going forward that could be supported by the self-identities of the narrator that are also consistent with developing interpretations about why this happened and how to stay safe? It is from within the boundaries sketched by those answers that the plan will arise.
Section III:  Project Implementation
Purpose

The purpose of this project is to evaluate the impact of trained psychiatric nurses using patient-centered narrative interviewing to influence the perceptions of primary care clinicians.

Rationale and Assumptions

Patient-centered interviewing is necessary but difficult to implement due to resistance by medical clinicians. Resistance may be related to a preference for the medical model, training and personality factors. The PCC may recognize the scope of change in personal style needed to fully implement the practice. Therefore the purpose of this project is to utilize specially trained psychiatric nurses as consultants to primary care clinicians (PCC), to conduct interviews and provide significant patient information back to those clinicians.

Other assumptions include the likelihood that the PCC is using clinician-centered interviewing approaches and therefore missing information such as unvoiced agendas, values, causal factors, and the beliefs/fears related to the outcome.

Overall Design and Objectives

In this project, psychiatric nurses were trained in patient-centered narrative interviewing approaches and placed in a variety of healthcare sites and conditions to function as consultants. The PCCs in those sites selected patients that each clinician felt was frustrating or difficult and arranged for the consultant to interview them. The consultants then presented patient information to the PCC, data typically difficult to obtain using a standard medical interviewing format. The consultant and PCC discussed the new information provided. The PCC then determined if the information provided was valuable, whether it changed their clinical decision-making regarding this patient’s diagnosis and treatment, if their previous level of frustration was improved as a result, and shared other impressions regarding the information or the process.
The objectives in this project include the following:

- Provide a process for the PCC to identify frustrating and/difficult patients.
- Collect quality and adequate biopsychosocial data using the patient-centered narrative interviewing process.
- Organize and effectively present this case to the PCC.
- Assess changes in the clinical decision-making, level of frustration, and other general perceptions of the PCC.
- Evaluate information for the purposes of modifying the approach in order to improve its value and acceptability.
- Determine how, when, and where to re-implement and/or expand the implementation of this project the future.

**Outcomes Evaluated**

**PCC perceptions of patient’s condition, diagnosis and treatment plans**

The Post Case Presentation Survey contains four questions evaluating how the PCC perceptions of their patient’s condition or situation, diagnostic impression, and plans for treatment were changed as a result of the information provided. These questions look at degree of change and specific types of changes in plans.

**Value of information provided to PCC**

Four questions on the survey assess the perception of value for the primary care clinician of the information provided in the patient-centered narrative interviewing process. One question asks the degree of importance this information represents, and another asks the PCC to attribute one or more of six different feelings to the value of this information. They could choose as many
responses as they felt applied. These attributes include “indifferent,” “conflicted,” “ambivalent,” “encouraged,” “hopeful,” and “enthusiastic.”

Two questions assess the readiness of the PCC to take action on the information provided. One question addresses the degree of confidence in the decision to take action, and one asks the timeframe during which the PCC might take that action (Hettema, Steele, & Miller, 2005). Finally, an open text field asks the primary care clinician to add other ways in which this information is most useful to them.

**PCC frustration**

Studies have shown that certain patient presentations and communication styles lead to clinician frustration. Higher medical utilization was associated with highly somatic patients and with physician’s perception of patient difficulty. (Lynch, McGrady, Nagel, & Wahl, 2007)

In a study evaluating the nature of practicing physicians’ frustrating visits, seven types of communication problems were identified including lack of trust/agreement, too many problems, feeling distressed, lack of understanding, lack of adherence, demanding/controlling patient, and special problems (Levinson, Stiles, Inui, & Engle, 1993).

A more recent study looking at the features of patient encounters that challenge medical students included student/patient emotional response, conflicting expectations, communication barriers, patient social circumstances, and the patient or family’s perception of the care plan (Bower, et al., 2009).

In order to collect information about clinician frustration, a survey question was included asking whether the PCC was more or less frustrated about the case after receiving the information from the case presentation. In addition, the clinician was asked to identify what frustrated them about this case and why they selected this patient for the interview on the
Clinician Problem Assessment form. The interviewer was also asked what he or she thought might have frustrated their preceptor about this case, and to list this information on the Interviewer Problem Assessment form.

**Differences between clinician and interviewer assessments of patient problems**

For the purpose of understanding more about the type of information provided from the patient-centered interviewing approach, both the interviewer and clinician problem assessment forms ask each to identify the patient’s main problems. Comparing this information should help to provide some insight into why the PCC may or may not find the information from the interview useful.

**Setting**

The project was conducted in a wide variety of primary care sites and services throughout the Bay Area and the Sacramento Metropolitan area, and the sites were selected because of previous arrangements with the healthcare services and organizations that operated them. All of these sites and clinicians are under contract with UCSF School of Nursing to provide clinical rotations for students in the Advanced Practice Psychiatric Nursing Program. The PCC’s involved in this project were already serving as preceptors to first-year students in the program.

The interviewers in the project were all students in the psychiatric nursing program at UCSF, and had already been assigned primary care clinical rotations in these sites. This author serves as clinical faculty for all the students participating in the project and coordinates placements. As part of their training, students conduct interviews and physical exams on the patients assigned to their preceptor, and then presents the findings from that case to the preceptor. The preceptor reviews the findings with the student and re-examines the patient as needed to verify findings or to instruct the student. The licensed clinician, and not the student,
makes all treatment decisions. Students had already been trained in previous courses to conduct these exams and to present their findings to the preceptor.

The choice of using students to be trained as interviewers in this project was based on several considerations. First, the students are all psychiatric nurses who are trained in basic patient communication skills, are familiar with medical and psychiatric settings, and are psychologically-minded as a result of their training and experiences. More importantly, nurses in general and the students in particular are more familiar with the biopsychosocial model and ascribe to the values of relationship building, dialogue and cultural humility. Also, compared to medical students and physicians in general, they are more likely have a higher tolerance for ambiguity and are more comfortable with psychosocial uncertainty.

Students involved in this project spend 2 to 4 hours weekly with this writer in didactic instruction and clinical seminar. The training in patient-centered narrative interviewing was an essential element in their clinical training and will be discussed in more detail in the next section.

**Training Approach and Method**

Training was conducted over a 12-week period from January through April, and included approximately 10 hours of classroom instruction and 30 hours of reading, practice, and other assignments. The content provided corresponded with the sequential and simultaneous components of patient-centered interviewing discussed previously, and as modified by narrative-based approaches. Methods of instruction included reading assigned articles, viewing videos, participating in discussions, developing individual and group create presentations, and performing and rating each other’s practice.

Training began with classroom presentations and reading assignments from books and articles on each of the topics and skills listed previously. Students then watched videotaped
demonstrations of the skills and learned to evaluate those performances for the degree of patient-centeredness versus clinician-centeredness, using the Patient-Centered Observation Form (PCOF) shown in the appendix.

Students progressed through self-learning modules of the skills on several websites, collected and summarized information individually and in groups, and then created a cumulative wiki to demonstrate mastery of the content. Next, they elaborated their findings from that project in formal presentations and discussions to the class as a whole. Simulations using scripts and rehearsed performances were subsequently employed to enable direct engagement and self-evaluation. Finally, using the PCOF in groups of three, students rotated the roles of interviewer, patient, and observer in a mock final exercise and each student was evaluated by the instructor prior to receiving permission to perform this task in their respective clinical settings.

**Intervention and Data Collection**

Each of the PCCs serving as student preceptors was notified of the students training and the assignment to interview the patient selected by their preceptor. Preceptors were invited to complete two additional forms for the purposes of the study. The preceptor invitation letter is included in the appendix with the IRB materials, and the other two forms can be found in the appendix with the study tools.

First, the preceptor was e-mailed instructions and a self-rating tool as a guide to identifying an appropriate patient. An abbreviated form of the self-evaluation tool for assessing communication frustrations with patients was included with the preceptor instructions, and may be found in the appendix of this document (Levinson, et al., 1993).

Patient-centered interviewing skills have proven more adept at disclosing underlying issues that lead to clinician frustration, such as unvoiced agendas, unexplored patient
perspectives, and other miscommunication. Therefore, to elicit PCC participation as well as examine the value of this intervention, the PCC was asked to choose a patient whose characteristics, situation, or behavior might be identified by that clinician as frustrating or difficult. The PCC was asked on the Clinician Problem Assessment form, “what frustrates you about this case? Why did you select this patient?” The PCC was instructed not to inform the interviewer of the reason for selecting this case. The interviewer was then asked on the Interviewer Problem Assessment form, “What do you think frustrated your preceptor about this case? Why did he or she select this patient?”

The interviewer was instructed to spend as much time as feasible under the circumstances or as necessary to achieve the goals as they had been instructed during their training sessions. Furthermore, the interviewer was reminded not to focus on making a diagnostic assessment, to perform a physical exam, provide more than minimum patient education, or conduct a psychiatric evaluation in order to emphasize the biopsychosocial goals of this interview.

After conducting the interview, the interviewer filled out the Interviewer Problem Assessment form, met with the PCC, delivered the findings in a typical case presentation format as they had been trained; and then the PCC and interviewer elaborated on areas of agreement and disagreement, according to the nature of the clinical situation, time utilization pressures and other contingencies.

Finally, the PCC would complete the Post Case Presentation Survey and give it to the interviewer along with the Clinician Problem Assessment Form. The student then added the Interviewer Problem Assessment Form, puts them in an envelope, and left them in the
instructor’s mailbox. No other or additional identifying information was requested other than that on the actual survey and assessment forms.
Section IV: Project Evaluation
Results

Twenty students and 17 PCCs were initially invited to participate in the project and evaluation. Nineteen students finished their assignments on time, conducting patient-centered interviews and serving as consultants to the PCC’s. Sixteen preceptors agreed to participate in the study in their roles as primary care clinicians. Twenty-one interviews and case presentations were conducted altogether. Two interviewers had two cases each, increasing the total number of interviews from 19 to 21. Three of the PCC’s served as preceptors for two students each, accounting for the PCC/interviewer difference.

Participant Characteristics

The nineteen interviewers were all licensed RNs (n = 16) with varying degrees of psychiatric and medical experience, predominantly female and Caucasian. The gender ratio of male to female was approximately 1 to 5. The age range extended from mid-20s to mid-50s. Approximately half of the interviewers came from a predominately psychiatric background while the other half had primarily medical backgrounds. Three of the interviewers have masters degrees and 16 have bachelors degrees.

Of the 16 PCC’s participating, one was a physician, two were physician assistants, and 13 were nurse practitioners. Among the practitioners, one was a PNP, five were FNPs, and seven were ANP’s. One third of the participants had psychiatric mental health training. Years of experience ranged from 2 to 30, and all were licensed to provide primary care services in their respective settings. Five of the PCC’s included psychiatric services in their scope of practice.

16 different healthcare sites were involved, and the settings ranged from primary care outpatient clinics to inpatient psychiatric units. Whatever the setting, all of these sites provided primary care services. The provision of psychiatric services was the main function of five sites,
while four sites offered both primary care and psychiatric services to their clientele. Seven sites provided only primary care services without any behavioral health or psychiatric component.

These psychiatric settings included three hospital inpatient psychiatric units and two psychiatric emergency services. The four combination settings included a state correctional Center, a mobile service providing care for the homeless, a community psychiatric treatment center, and a residential treatment center. Seven settings providing primary care without behavioral health services included two veterans’ administration outpatient clinics, an elder care clinic, a health maintenance organization outpatient clinic, two community health Center clinics and one private practice.

No individual patient information was requested or obtained. However, the clientele receiving services from the sites described cover a broad demographic range from privately insured and employed individuals and families to homeless, incarcerated, and seriously mentally ill individuals. Although five sites provided services to children as well as adults, all of the clients interviewed for this project were adults.

The diagnostic range of conditions in the 21 cases involved in this project was equally broad. The psychiatric conditions listed on the Clinician Problem Assessment form included the following: substance abuse, bipolar disorder, anxiety, depression and suicide attempt, schizoaffective disorder, psychotic disorder, somatization disorder, schizophrenia, dementia, among others. The medical conditions listed included the following: chronic back pain, stomach pain, celiac disease, cellulitis, hypertension, dyslipidemia, emphysema, arthritis, gastroesophageal reflux disease, medication side effects, asthma, among other conditions.
Outcomes

PCC perceptions of patient’s condition, diagnosis and treatment plans. As a result of the information provided in the 21 patient-centered interviews, all but four of the primary care clinicians felt that they understood their patient’s condition or situation differently. In 12 cases the PCC’s perception was somewhat different, and five cases it was definitely different.

In almost half of the 21 cases, the PCC changed their diagnostic impression of the patient’s condition as a result of the information provided. They felt that it was changed somewhat in eight cases, and definitely in two cases. In 11 cases, the diagnostic impression was unchanged as a result the information provided.

Nearly all the primary care clinicians however, reported that they would change their treatment plans based on the information provided. In 13 cases, they reported that their plans were affected somewhat, and in five cases that they were definitely affected. In only three cases did they report that the treatment plan unaffected. Specifically, PCCs reported that they would change their general approach to the patient in 11 cases and the sequence of the treatment or its timing in eight cases. PCCs reported they would chose to make a referral to another clinician in nine cases, change or add a prescription in six cases, and order additional testing or evaluations in four cases. No one reported that additional labs were needed. Other treatment plans listed included meeting with other clinicians, close follow-up of the patient, addressing specific areas with the patient, getting a fresh perspective, and staff interaction.

Value of information provided to PCC. All of the primary care clinicians reported that the information provided from the patient-centered interviewing approach was important. In responding to this question, they were instructed to choose as many or as few items as they each felt was appropriate to characterize ways this information was valuable to them. Because of this
selection option the choices were distributed as follows: In 10 cases they reported that it was somewhat important, and in 11 cases it was reported to be very important. In nearly all cases the primary care clinicians attributed positive feelings to the information provided. Of the 32 responses to this question, “indifferent” was selected once, and “ambivalent” chosen twice. On the other hand, “encouraged” was selected 16 times, “hopeful” 10 times, and “enthusiastic” four times.

A further appraisal of the value of this information was determined by the readiness of PCCs to take the actions they selected in previous questions. This motivational interviewing approach assessed their confidence in their decision to act in the time frame in which that action was anticipated. No attempt was made in this study to determine whether any clinician actually did, in fact, actually act on those decisions. These primary care clinicians appeared quite confident with their plans. Of the 18 responses, 15 reported they were “very” confident and three that they were “somewhat” confident. As to when they would take action, nine listed “now,” five chose “within 30 days,” six chose “less than six months.”

Some of the comments added by the primary care clinicians to describe ways in which the information provided from the interview was useful to them included the following statements:

“Helps me with overall understanding and treatment planning,” “To put a plan together that will anticipate the patient’s needs prior to presenting with a health decline,” “Helpful in giving additional information and another perspective,” “Helped me think about the case from a broader perspective,” “Reinforced diagnostic impression,” “Mental health is as important as the medical issues presented,” “It gives me good insight into the patient’s behavior,” “This information made her more approachable and more straightforward to deal with,” “Provided me
with alternative insight and viewpoints on approach and technique with his patient,” “Found impressions very helpful to my end decision,” “Knowing history of drug use will guide me in deciding interventions for enhancing client motivation and self esteem.”

**PCC frustration.** Half of the primary care clinicians in this project reported less frustration as a result of the information provided to them. The frustration levels reported in the other half of the PCCs remained unchanged. One clinician reported more frustration after hearing the information. PCCs listed the following descriptions and characteristics as the sources of their frustration:

Lack of responsibility for actions, manipulative behaviors, medication seeking behaviors, attention seeking behaviors, chronic pain problems, refusal of care, noncompliant, multiple comorbid conditions, lack of motivation, “says one thing and does another,” inconsistency of information provided, demanding, controlling, high level of complexity, frequency of service use, “irritable and difficult to communicate with,” “needy patient,” patient distrust of system, time constraints, patient lack of insight, evasiveness, complex patient but limited time, “hyperactive and hyper verbal patient,” refusal of referrals, somatization, “poor temper,” and non-adherence.

**Differences between clinician and interviewer assessments of patient problems.** Comparison of problem assessments between interviewer and clinician on the forms submitted revealed several findings. To a small degree, the primary care clinicians tended to list medical and psychiatric conditions, while the interviewers identified psychosocial problems. However, in most of the cases the actual iteration of diagnoses was similar between clinician and interviewer. For example, the clinician might list several medical problems including noncompliance and anger management issues, and the interviewer might add “mistrust of military system.” In
several cases the interviewer either identified an additional psychiatric diagnosis or elaborated on the clinicians description. For example, the interviewer might describe the influence of substance abuse, medical or psychiatric condition. In many cases, the interviewer listed patient limitations, such as a patient’s lack of knowledge regarding plans or her limited resources. In several cases, the interviewer listed the patient’s perspective and the priorities, such as the patient’s weight and self-esteem issues, or anxiety and worry so severe it interfered with adherence to treatment plan. The interviewer might explain the source of a patient’s frustration; the specific psychosocial needs, and/or attribute other etiologies to the patient’s stress or behavior. These included statements such as, “attachment trauma from parental abuse,” and “somatization secondary to death of spouse.”

**Analysis**

**Participants and Sites**

Nearly 100% participation was obtained with 19 of the 20 interviewers and 19 of 20 primary care clinicians. This was likely due to the fact that the sites and clinicians had a pre-existing relationship with the University nursing program, were familiar with their role as preceptors, and were already working with the students before this project was undertaken.

Of the 16 PCC’s participating all but three were nurse practitioners, and their nursing background may have influenced the value of the biopsychosocial information provided to them and their acceptance of that approach. Similarly, the number of years of nursing experience in a psychiatric versus medical setting may have had some influence on the success of the PCC’s abilities to detect more subtle clues in patient presentations, and to tolerate ambiguity and uncertainty.
The frequency of psychiatric diagnoses listed on the Clinician Problem Assessment form is consistent with the representation of psychiatric settings, services providing both psychiatric and medical functions, and the population served by these settings and services. None of the studies this writer evaluated for this project included patient-centered interviewing approaches in psychiatric settings or with mental health conditions. However, the value of the information provided from this approach was high and had a substantial influence on the primary care clinicians overall. It cannot be determined from the data provided weather information was more valuable and or more influential in medical settings compared to psychiatric settings.

Outcomes

PCC perceptions of patient’s condition, diagnosis and treatment plans. PCCs reported changes in their perceptions after the case presentations of information obtained employing a patient-centered interviewing approach. The degree of change was surprising and unanticipated, although gratifying. These clinicians reported they understood their patient’s condition better, and as a result they listed the changes in both diagnoses and treatments they were planning to make. The smaller degree of change in diagnoses compared to treatment plans makes sense because diagnostic criteria are typically precise. On the other hand, a modification in treatment approach would be predicted as more likely to occur due to a better understanding of a patient’s illness experience and the nature of their situation. This is precisely what would be expected when an evidence-based clinical diagnosis and treatment approach is integrated with the context provided by the biopsychosocial approach.

Another surprising finding was the frequency with which PCCs indicated choices to change or add a medication. It is understandable that a different appreciation of the patients situation and diagnosis would lead to referrals to other clinicians and to the alteration of the
general approach and/or sequence, but listing changes in the pharmacologic management of a condition or disease under the circumstances was not expected. Both the referrals and the medication choices may have been due to the addition or further substantiation of a psychiatric disorder and the decision to add or modify treatment as a result.

One point needs to be clearly re-stated here. The PCCs in this study listed changes they planned to make in their patients’ diagnosis and/or treatment plans, and they reported confidence in those decisions and selected a timeframe in which they would take that action. However, it is unknown whether any of those clinicians actually followed through on those reports, nor is it known whether outcomes were at all improved as no chart review was performed in this project.

**Value of information provided to PCC.** 95% of PCCs reported that this information was somewhat or very important. In addition, the most frequent description attributed to how they felt about that information was “encouraged” and “hopeful.” In four cases the clinician was even “enthusiastic” about the information they heard.

Further evidence for this broad and very positive evaluation and acceptance could be seen in the degree of commitment they reported to implement the new treatment plans. 83% were very confident with their plans and 70% take action now or within 30 days.

The comments made by PCCs about the value of the information provided reinforce the impression and are consistent with the goals of the project. Clinicians reported their patients were more approachable and they had more insight into their patient’s situations. The information also appeared to provide them with alternatives and clarified what they were dealing with.

**PCC frustration.** The statements made by clinicians regarding particular patient behaviors or clinical situations frustrating them is consistent with the literature described earlier
in this paper. PCCs identified communication issues, multiple complaints, somatic presentations, and time constraints as features that frustrated them. Reducing a clinician’s frustration as well as clarifying diagnostic impressions, patient conditions, and treatment choices should make acceptance of patient-centered narrative interviewing with these clinicians easier in the future.

**Differences between clinician and interviewer assessments of patient problems.** It was clear from the diagnostic lists provided by clinician and interviewer that there was significant overlap in the cases between both psychiatric and medical conditions as well as a more integrated biomedical and biopsychosocial approach. As discussed earlier, this may be due to the nursing background of most of the primary care clinicians who participated, and/or the significant psychiatric experience that characterized this particular group.

What was added by the interviewers appeared to be a further elaboration of the patient’s condition, more perceptible rationales for their behaviors, and specific identified needs for education and/or other resources. In any case, it is clear that the primary care clinicians found this information valuable and important enough to change their diagnostic impressions and plans for treatment.

**Discussion**

It is evident from the self-reports of PCCs that perceptions were altered after consultations with RNs who sought to understand the context of the patients’ conditions. As a result of information provided from the interviews, clinicians reported modifications in their patients’ diagnoses and treatments. This form of interviewing reduced clinicians’ self-reports of frustrations and provided them with information they portrayed to be extremely valuable.

However, several things are not known. Most importantly, did PCCs actually make those changes in diagnoses and treatment plans and were they recorded in their patient’s charts? Would
clinicians involved in this project want to do it again? Would they take advantage of other opportunities to use consultants in similar ways? As a result of this experience, are any of them interested in pursuing this kind of training themselves? Unfortunately, none of these questions was asked in the survey and no follow-up or chart review was done. The next step would be to determine their willingness to have another student perform this role in the future, to make use of other clinicians both inside and outside their practices who could offer this, or to attend and/or pay for training themselves. Is this something they think should be provided routinely? What patients do they feel would benefit from this approach? When might this approach be essential?

The issues raised in the previous section regarding this particular patient/physician/service mix also need to be addressed further. This was not the typical physician-staffed primary care outpatient clinic setting or patient-centered medical home described in the literature of patient-centered interviewing, biopsychosocial approaches, or narrative medicine applications. Did a nursing background of the interviewer affect the results? Did the nursing background of the PCC have an effect? If this project were repeated in strictly outpatient primary care medical clinics, would we see the same results?

What effect did the dual role of preceptor and direct care clinician have on the participants’ responses? Did familiarity with the interviewing RN, who was also their supervisee, have a confounding effect on their appreciation of the information? If that student had instead performed a standard biomedical interview and presented that information, would similar changes in diagnoses and treatment plans be reported?

Finally, did interviewers actually perform patient-centered narrative interviewing as they were trained? Although their performance in the lab situations verified their ability to conduct this type of interview, neither faculty nor preceptor observed or evaluated the performance in an
actual physical situation. This is important because students face a number of different conflicting influences and modeling, especially in their first year of the psychiatric nurse practitioner training program. In this program, students are trained to conduct a medical interview and are placed in medical settings watching other clinicians perform this role, and they are trained to conduct psychiatric evaluations in settings where this is expected and modeled.

In addition, their preceptors may have never heard of patient-centered narrative interviewing, and this was likely their first exposure to it. Did this lack of precedent help or hinder the student and/or the conduct of the interview?
Section V: Next Steps
This project attempted to implement a patient-centered and narrative-based interviewing approach into primary care practices by using psychiatric nurses as consultants to the patient’s primary care clinician. This approach was chosen specifically because of medical clinicians’ disinclination towards consultation methods that they suspect might require more time to perform and that are seen as less rigorous when compared to a medical model orientation of data collection. This paper also showed evidence to suggest that medical clinicians experienced distress in situations that are ambiguous or uncertain, such as reading psychosocial clues, eliciting patient perspectives and beliefs, and identifying and tracking unclear topics.

This paper presented the development of this project as an evolution initiated by a series of attempts to implement the patient-centered mandates sought by the Institute of Medicine’s reports and occasioned by the patient-centered medical home movement. The difficulty in adopting patient-centered approaches was also presented in this paper as an aspect of the duality expressed in the biomedical versus biopsychosocial approaches.

In this context, this project represents a small test of change in a larger effort on many fronts to make what are seen as critical transitions towards a new health care system. Another dimension of this same process has been taking place over the past decade in the movement to implement evidence-based practice (EBP) more consistently and dependably in clinical practices. EBP implementation is well researched and defined, but still inconsistently applied. This makes EBP the perfect place for CQI initiatives. Since CQI is an analytical decision-making tool to determine whether a process is working predictably or not, it makes sense to apply these methods in the context of EBP implementation efforts.

Practitioner EBP use, as well a significant failure rate of implementation, has been demonstrated to be affected by a number of factors, including training, clinical setting,
organizational culture, and practitioner attitudes (Midgley, 2009; Nelson & Steele, 2007).

Complicating these issues is the directive in EBP criteria that the practitioner considers patient preferences. Shared medical decision-making is an approach and model designed to incorporate patient preferences into evidence-based practice. However, some have suggested that evidence-based practice and shared decision-making are such different approaches that they are fundamentally incompatible. This argument is reminiscent of the complaint raised by biopsychosocial practitioners that implementation of that model in the current medical practice environment may not be feasible. The split or transitional model was offered as a temporary alternative (Barratt, 2008; Krahn & Naglie, 2008; Murad, Montori, & Guyatt, 2008).

Therefore, while a CQI approach to performance measures and clinical indicators is consistent with the current state of evidence-based practice, patient-centered narrative interviewing still suffers from a lack of clear performance criteria and consensus regarding when it is indicated. Thus the strict adoption of CQI methods and practice for patient-centered narrative interviewing approaches is fraught with difficulty. On the other hand, this writer believes that the lessons learned in EBP implementation attempts can be instructional in future efforts to introduce patient-centered interviewing as additional small tests of change in settings and conditions not yet explored by this project.

In the rest of this section, the intent and goals of the current project will be situated within the iterative processes of performance improvement discussed previously in this paper, and future plans for its continued development and implementation will be explored. As discussed in the first section of this paper, this project has its roots in a series of iterative developments designed to move the current healthcare system from a clinician-centered to a patient-centered system. The Institute of Medicine identified serious flaws in the current healthcare system
practices that led to increased morbidity and mortality and offered a prescription for change. Thus began a series of projects on a national level whose efforts produced an array of adjustments and modifications to improve on the lessons learned in the project.

From the patient-centered medical home national demonstration project, came one of those lessons learned. That large project, and several that were less grand in scope, first raised the red flag regarding the difficulties of this transition. In particular, program planners and policy developers are cautioned about the significance and degree of the type of change needed from individual physicians in order to successfully move to a patient-centered approach.

That lesson and warnings were reinforced by this writer’s experience with the original plans for this project. Those plans called for the recruitment of primary care clinicians who would be trained in patient-centered narrative interviewing approaches and return to implement these approaches in their own practices. The training in those initial plans called for reading assignments and online modules to be completed at home, then a weekend workshop would be provided consisting of cases, demonstration and rehearsal of the skills. Finally, consultations would be offered in which participants received telephone, online, and on-site support from the trainer-facilitator. However, serious difficulties arose and made this approach impossible. Problems encountered included institutional roadblocks from the organizations, Limited interest from clinicians, and the near-impossibility of scheduling meeting times based upon available schedules of those who did express interest.

Thus the current project selected students who were also psychiatric nurses in order to overcome some of the limitations experienced in the initial project design and revealed in the literature. Psychiatric nurses had demonstrated their commitment to dialogue and to relationship building, and they tend to be psychologically minded. This meant that they were comfortable in
reading behavioral clues already and identifying the unspoken needs of their clients and patients. In addition, they were more likely to be tolerant of ill-defined situations and more comfortable with that type of ambiguity. Finally, the training program in which they were involved required them to learn primary care skills and work in primary care settings, an advantage that would not likely exist if the participants were social workers or other counselors.

In the previous section, several limitations of the current study were identified that needed to be addressed in subsequent iterations of the project. A number of sites in the current project included patients whose full participation was impaired as a result of drug use, impaired level of consciousness, psychotic symptoms, and unstable medical conditions. When repeating this project in other sites, these conditions would be best excluded.

Other limitations included insufficient time for PCC orientation to the project and time for the PCC to identify appropriate patients. Ideally, the clinician using the scale and/or instructions provided should identify the patient, and those patients should be called to schedule an appointment with the student/interviewer. In that way, a full 1 to 2 hours could be devoted to the interviews, and it might be possible for each interviewer to perform 3 to 5 evaluations over a longer time frame. Interviewers should also be surveyed to identify problems that they experienced over the course of participation in the project as well as in the patient interviewing sessions in order to provide a change of course in the next iteration.

Finally, the clinicians/preceptors who did participate could be surveyed to determine their interest in continuing this project next year and over a longer time frame. In addition they could be asked if they were personally interested in similar training and asked how they might implement that into practice, given the apparent enthusiasm and positive results from the current projects implementation. Therefore the next iteration of this project could be the one that was
originally planned using pre-workshop, workshop, and consultation approaches.

This project could go several directions from here. It can, as discussed here, be repeated next year over a longer time frame and with a modification of approaches as listed. It could also take the form of training primary care clinicians directly and consulting with them on implementation. The lessons learned from those approaches would permit incorporation of these methods into a larger consultation service, such as a Primary Behavioral Health Consultation Service (PBHCS).

A PBHCS could incorporate the patient-centered narrative interviewing approach as a method in an array of services that would also include working with primary care clinicians to improve their skills in diagnosing and managing psychiatric conditions, and in incorporating health behavior change practices needed for risk reduction and disease prevention. This writer has already procured many necessary elements and tools needed to implement this service, including practice assessment surveys, staff orientation modules, service request forms, chart documentation materials, and clinician training manuals.

Typical offerings by the PBHCS would include the following functions:

- **Triage/liaison** – initial screening visit of 30 minutes or less to determine level of care
- **Behavioral health consultation** – initial visit for general and diagnostic evaluations, treatment recommendations, behavior-change goals, or assessment of more acute risks.
- **Behavioral health follow-up** – secondary visit based on earlier consultation typically at the same time/piggy-back with PCC visit.
- **Compliance enhancement** – to address educational and counseling needs based on negative beliefs, medication side effects strategies, motivational counseling approaches.
- **Relapse prevention** – spaced at longer intervals, these visits are intended to maintain and
support maintenance of adopted positive behavioral changes

- Behavioral medicine – visits focusing on lifestyle modification or health risk behaviors, or to assist with management of a chronic medical condition

(Primary Behavioral Health Care Services Practice Manual, 2002; Robinson & Reiter, 2007)
Section VI: Implications for Advanced Practice Nursing
Concurrence with Nursing Theory

Several themes have emerged throughout this paper that resonate with existing nursing theory. Drawing additional insights from nursing theory is particularly important in order to understand the nature and significance of the personal transformation required to fully engage in the practices described in this paper, and to clarify efforts needed to be successful in achieving the objectives of patient-centered narrative interviewing.

Margaret Newman’s (2008) work helps explain why the narrative-based mode makes such an important adjustment to the patient-centered interviewing skill set. Newman’s exploration of the nurse-patient dynamic, with its emphasis on pattern, dialogue, meaning and relationships as a part of nursing praxis, gives substance to estimates of the effort needed to make this shift from theory and skill to a fully embodied practice.

For Newman, health as expanding consciousness (HEC) is what the shift is all about. HEC in nursing praxis represents the transition from a rational objective approach to an intuitive unitary approach. Praxis is what fosters change through self-reflection and deeper understandings of our situations. It is this insight into pattern that shows the potential for action. A special function of this pattern recognition is the meaning that a particular illness has for each person and the disruption that it signifies (p. 22-25). That concept fits closely many of the functions of narrative described earlier in this paper as it pertains to the patterns emerging as a patient tells the story that the practitioner receives it and reflects it back.

Engaging in a dialectic process within the structure of the interview is the mechanism both for uncovering agendas and clues as well as discovering potential. Newman explains that dialogue is a meaning-making transformative process. Engaging in this process, nurses experience a
paradigm shift in their patients as well as their own perspectives. In fact, Newman believes that the goal of nursing is to provide this kind of a transforming presence (p. 26-31).

This process focuses on storytelling as well, according to Newman. A shared narrative develops between nurse and patient and becomes the basis for joint action. As this narrative is developed, meaning emerges through reflection and pattern recognition, and a new way of seeing seems to take place. (p. 67) This kind of engagement may even occur during a simple wound care visit. Insight emerges under circumstances when the nurse concentrates fully and unconditionally on what is most meaningful to the patient, and helps that patient get to the essence of what she needs to express (p. 34).

Another theme addressed throughout this paper is the concept of patterns or ways of knowing. This was discussed in terms of the biomedical versus the biopsychosocial mode, as well as the conundrum involved in merging evidence-based practice with patient preferences.

Newman’s fundamental concept of health as expanding consciousness suggested a transition from an objective to an intuitive approach as a key part of nursing praxis. This might seem to imply that Newman and this writer advocate one as opposed to the other; that narrative or intuitive or biopsychosocial ways of knowing are more viable than positivistic or evidence-based or rational ways of knowing. This is not the intent. Instead, these alternative ways of knowing advocated in this paper and by Newman need to be championed because of their devaluation in the medical practice today and their continuing importance to understanding of patients’ conditions.

As described in this paper, narrative and biopsychosocial ways of knowing provide data significant enough to change the diagnostic impressions and treatment plans for primary care clinicians. In addition, they provide the context that allows clinicians to implement evidence-
The debate over these fundamental patterns of knowing is not new to nursing, and has been argued ever since Barbara Carper set forth her understanding of these patterns in 1978. However, with the rapid ascent of empiric and positivistic knowing, there has been concern that what Carper called the aesthetic pattern of knowing had become an excuse or justification to dismiss scientific approaches and evidence-based practices in nursing. This debate basically asks if these ways of knowing are independent and equal, primary and secondary, or in some fashion integrated (Carper, 1978; Duff Cloutier, Duncan, & Hill Bailey, 2007; Paley, Cheyne, Dalgleish, Duncan, & Niven, 2007).

What this paper adds to this debate is more evidence not only that they are indeed integrated but also even how that function might take place. If unvoiced agendas are to be heard, if social, emotional, and narrative clues are to be followed, and if patients’ dislocated self-identities are to be repaired; then aesthetic patterns of knowing must be valued and incorporated into practices. By doing so, we not only enhance the accuracy of evidence-based practices, we show where and in what ways EBP might be put to work and improve the life of someone who most needs it in a particular way. Narrative and aesthetic understandings offer a way home for logico-scientific knowledge and evidence-based practices.

Concurrence with DNP Competencies

The Practice Doctorate Nurse Practitioner Entry Level Competencies articulated by the National Organization of Nurse Practitioner Faculties (NONPF) in 2006 identified nine areas in which practice doctorate nurse practitioners should demonstrate proficiency, in addition to the nurse practitioner specially competencies. Each of those competencies appropriate to this project will be discussed.
Competency Area: Independent Practice

As described earlier, future iterations of this project are planned that include a Primary Behavioral Health Consultation Service, in which Psychiatric Mental Health Nurse Practitioners function in an independent and interdependent role as consultants to primary care clinician teams. In this role the PMHNP assumes full accountability as a licensed independent practitioner.

Competency Area: Scientific Foundation

The design of this project required this writer to integrate knowledge from nursing’s philosophical framework, and from medical practice, health policy, behavioral health, and primary care in order to develop a training program and to implement the project within the primary care setting.

Competency Area: Leadership

Leadership has been demonstrated within this project by negotiations with healthcare organizations, primary care clinicians, nursing faculty, and others to establish the training program and the project in its current form. Additional leadership will be required to establish the planned PBHCS as envisioned in this paper.

Competency Area: Quality

The goal of this project was to enhance patient-centered practices in clinical settings as envisioned by the Institute of Medicine and the patient-centered medical home model. This required an understanding of the intersection of organizational dynamics and health policy decisions and their impact upon quality and accessible care. In addition, a comprehensive
literature review was required in order to identify evidence-based patient interviewing methods and skills.

**Competency Area: Practice Inquiry**

Development of the methods utilized in this project required the substantial familiarity gained from clinical practice in order to determine an appropriate and feasible method to implement evidence-based patient-centered services in multiple complex healthcare environments encompassed by the project. Translating difficult concepts and new skills into a coherent clinical practice format was required.

**Competency Area: Technology & Information Literacy**

Translating technical and scientific health information appropriate for user needs was required in the performance of this project in order to perform literature searches and translate research into understandable language and observable skills.

**Competency Area: Policy**

As demonstrated in the early sections of this paper, a fundamental grasp of the implications of health policy and its impact on health care reform was required. The practices and goals of this project needed to be consistent with the overall and future direction of this developing healthcare policy initiative in patient-centered care.

**Competency Area: Health Delivery System**

As discussed above under leadership and practice inquiry, implementation of this project required knowledge of organizational behavior and systems as well as skills in partnering, negotiating, and consensus building.
Competency Area: Ethics

The principles upon which this project is based, are consistent with a sound ethical approach to patient care. These principles emphasize the respect and appreciation for individual values and differences and the delivery of services that are sensitive to those differences.
References


Launer, J. (2002). *Narrative-based Primary Care*. Oxon, United Kingdom: Radcliffe Medical Press Ltd.


Appendices:

A. Illustrations & Graphs

1. Screen Shot of On-line Training Site
2. Change in Frustration after Case Presentation
3. Value of Interview Information
4. Change in Diagnosis
5. Change in Treatment Plan
6. Type of Treatment Change
Screen Shot of On-line Training Site

**Interviewing: Foundation Skills**

- Doing the Psych Eval: Excerpts from "First Interview"
- Areas of the Psychiatric Interview - from APA
- Interview Dynamics Graph
- Simultaneous & Sequential Interview Skills
- An Overview of the Art of Interviewing - David E. Reisner
- Agenda setting in the Clinical Interview
- Video Series: Interviewing Basics

**Mastering the Clinical Interview**

- Mastering the Clinical Interview.mp3
- Mastering the Clinical Interview - Handout

**Interviewing: Relationship Skills**

**Demo & Self-Assessment**

- Video - Demo of Relationship-building in a clinical interview
- Self-Assessment: Communication in Relationship-Building
  - PCOF: Use in self assessment exercise

**Communication Areas in Relationship-Building**

- Wiki: Communication in Relationship
- Communication Wiki FORUM for Group Discussions

**Readings**

- Interacting With The Medical Humanities: The Doctor-Patient Relationship
- "Words That Build Empathy" article link
- "Inside" the Patient-Centered Interview - link to article
- Relationship, Communication, and Efficiency in the Medical Encounter - link to article
- "Building" vs. "Taking" a History - link to article: ACCESS VIA VPN ONLY
- Clinician Behaviors that Inhibit Disclosure of Psychosocial Problems during Interview - link to article
- "Unvoiced" Patient Agenda Items - link to article
- Depressive Symptoms and Perceived Doctor-Patient Communication
- Narrative-Based Practices in Primary Care
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Change in PCP Frustration

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Legend:
- Blue: Unchanged
- Red: More
- Yellow: Less
- Green: N
### Changed Dx

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<td>Lab</td>
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<td>Test</td>
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</tr>
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<td>Other</td>
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<td>N</td>
<td>44</td>
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</tbody>
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Appendices

B. Forms & Tools used in Study

1. Instruction/Invitation Letter to Preceptor/PCC

2. Selecting a Patient for Student Interview
   
   Instructions

3. Clinician Problem Assessment form

4. Interviewer Problem Assessment form

5. Post Case Presentation Survey

6. Patient-Centered Observation Form (PCOF)
Students have been trained in Patient-Centered Narrative Interviewing over the past quarter and are prepared to put those skills to work. They need you to identify at least one, and hopefully two or more patients over the month of April for them to interview and present to you after the interview. The focus of their interview will be on the biopsychosocial aspects of the patient’s condition rather than the biomedical aspects alone. The patient you select should be a case with which you are at least somewhat familiar and find challenging and even frustrating due to somatic complaints, multiple problems, high clinic utilization, and/or difficulty due to how they perceive their problem and treatment expectations versus the way you as their clinician perceive it. I have attached a patient selection guide that should help you select cases for students to interview. After the student presents the case to you, please take time to discuss the case and compare your findings. The student will also be presenting that case in class during clinical seminar.

I would like to invite you to help me evaluate the effectiveness of the student's interview technique in order to adapt my teaching. PLEASE HELP ME EVALUATE THIS by taking a brief (3-5 minutes only) survey about how this information might or might not have affected your clinical decision-making.

So here is the sequence:

1. Select a case for the student to interview using the Pt. Selection Guide (attached).

2. Fill out the Clinician Problem Assessment (attached) with your information on this case, but hold on to that info until she presents the case to you.

3. Have the student interview the family. This will likely take 60-90 minutes to complete.

4. The student then presents the case to you, and you both discuss the case.

5. Finally (Please!) fill out the Post Case Presentation Survey (attached)

6. Give the Survey and Problem Assessment to the student to return to me.

Also please let me know if you are willing to fill out the survey and participate in the evaluation!

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Clinical Assistant Professor
Psychiatric Nurse Practitioner Program, UCSF School of Nursing
2 Koret Way Box 0608 San Francisco, CA 94143-0608
(415) 502-4427 office (415) 637-1810 cell
Selecting a Patient for Student Interview

Please use the items below as a guide to identifying a patient. This is only intended as a guide/adjunct. You do not actually need to fill this out! When thinking about your patients, is there someone who meets some of the following characteristics?

<table>
<thead>
<tr>
<th>Item:</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of trust or agreement</td>
<td>1 2 3 5</td>
</tr>
<tr>
<td>1. There was a lack of trust between us.</td>
<td></td>
</tr>
<tr>
<td>2. The patient was unwilling to accept the diagnosis.</td>
<td></td>
</tr>
<tr>
<td>3. The patient and I could not see eye to eye on the goal of the visit.</td>
<td></td>
</tr>
<tr>
<td>4. I felt that the patient didn’t believe me.</td>
<td></td>
</tr>
<tr>
<td>Too many problems</td>
<td>1 2 3 5</td>
</tr>
<tr>
<td>5. The patient had a million complaints.</td>
<td></td>
</tr>
<tr>
<td>6. There were too many problems.</td>
<td></td>
</tr>
<tr>
<td>7. I spent more time in the visit than I wanted to.</td>
<td></td>
</tr>
<tr>
<td>8. On the way out the door, the patient said, “Oh, by the way . . .”</td>
<td></td>
</tr>
<tr>
<td>Feeling distressed</td>
<td>1 2 3 5</td>
</tr>
<tr>
<td>9. I felt depressed after seeing the patient.</td>
<td></td>
</tr>
<tr>
<td>10. There were times when I didn’t know what to do next.</td>
<td></td>
</tr>
<tr>
<td>11. I felt angry after seeing the patient.</td>
<td></td>
</tr>
<tr>
<td>12. I felt overwhelmed.</td>
<td>1 2 3 5</td>
</tr>
<tr>
<td>Lack of adherence</td>
<td>1 2 3 5</td>
</tr>
<tr>
<td>13. The patient didn’t follow my instructions.</td>
<td></td>
</tr>
<tr>
<td>14. The patient had not complied with the therapy I prescribed.</td>
<td></td>
</tr>
<tr>
<td>15. The patient did not accept responsibility for his/her own health care.</td>
<td></td>
</tr>
<tr>
<td>Lack of understanding</td>
<td>1 2 3 5</td>
</tr>
<tr>
<td>16. The patient couldn’t give me a clear history.</td>
<td></td>
</tr>
<tr>
<td>17. We couldn’t understand each other.</td>
<td></td>
</tr>
<tr>
<td>18. I couldn’t understand what the patient wanted to tell me.</td>
<td></td>
</tr>
<tr>
<td>Demanding/controlling patient</td>
<td>1 2 3 5</td>
</tr>
<tr>
<td>19. The patient was trying to manipulate me.</td>
<td></td>
</tr>
<tr>
<td>20. The patient was too controlling.</td>
<td></td>
</tr>
<tr>
<td>21. The patient was telling me what to do to diagnose or treat the problem.</td>
<td></td>
</tr>
<tr>
<td>22. The family was demanding and complaining.</td>
<td></td>
</tr>
</tbody>
</table>
Clinician Problem Assessment

What frustrates you about this case? Why did you select this patient?

What do you see as the patient’s main problems? (List as many as you feel important)
1.
2.
3.

Interviewer Problem Assessment

What do you think frustrated your preceptor about this case? Why did s/he select this patient?

What do you see as the patient’s main problems? (List as many as you feel important)
1.
2.
3.
Post-Case Presentation Survey

1. Do you understand your patient’s condition or situation any differently?
   - Unchanged
   - Somewhat
   - Definitely

2. How do you feel about the information from the interview? (check all that apply)
   - ____ Indifferent
   - ____ Ambivalent
   - ____ Conflicted
   - ____ Encouraged
   - ____ Encouraged
   - ____ Enthusiastic

3. How important to you is this information to you at this point?
   - Not at all
   - Somewhat
   - Very

4. Are you more or less frustrated about this case than before this information was presented?
   - More
   - Less
   - Unchanged

5. Has the information provided changed your diagnostic impression?
   - Not at all
   - Somewhat
   - Definitely

6. Does the information provided affect your plans for treatment?
   - Not at all
   - Somewhat
   - Definitely

7. If so, in what ways? (check all that apply)
   - ____ General approach to patient
   - ____ Timing or sequence of treatment
   - ____ Referral(s)
   - ____ Medication(s)
   - ____ Lab
   - ____ Other testing or evaluation(s)
   - ____ Other ________________________

8. If no, what are your plans at this point?
   - Nothing
   - Think
   - Find out
   - Right now
   - about it
   - more
9. How confident do you feel about that decision?
   Not at all       Somewhat       Very

10. At what point might you be willing to take that action?
    Never       < 6 mo.       > 6 mo.       Within 30 days       Now

11. In what ways is this information most useful for you?

12. Is there anything else you’d like to add?
# Patient Centered Observation Form

**Trainee name:**

**Observer:**

**Observ**

**Date:**

**Directions:** Make notes using row headings to help organize your observations. Record important provider behaviors and comments, patient comments, verbal or non-verbal cues, and your thoughts and questions. Check one box per numbered row, eg. either 1a or 1b or 1c; then either 2a or 2b or 2c, etc.

Desired behaviors are in columns to the right of the wider line.

Use this form to guide verbal feedback and to enhance your own learning.

<table>
<thead>
<tr>
<th>Element</th>
<th>Provider Centered Biomedical Focus</th>
<th>Patient Centered Biopsychosocial Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishes Rapport</td>
<td>1a. Uses 0-1 of the following: introduces self; eye contact; warm greeting; non-medical interaction; humor, acknowledges all in room by name</td>
<td>1b. Uses 2 of the following: introduces self; eye contact; warm greeting; non-medical interaction; humor, acknowledges all in room by name</td>
</tr>
<tr>
<td>Maintaining Relationship Throughout Visit</td>
<td>2a. No evidence of empathy</td>
<td>2b. Conveys empathy non-verbally and verbally</td>
</tr>
<tr>
<td></td>
<td>2a. No verbal listening behavior</td>
<td>2b. Uses continuous phrases (eg. summing up) or repeats patient's phrases</td>
</tr>
<tr>
<td></td>
<td>2a. No evidence of mindfulness: disease focused, distracted and not person focused.</td>
<td>2b. Mild evidence of mindfulness: curiosity or presence of reflection.</td>
</tr>
<tr>
<td>Establishes Focus</td>
<td>3a. No elicitation, dove into diagnostic sequence on patient's 1st problem, or MD focuses on his/her concerns.</td>
<td>4a. Does not acknowledge pre-visit info or confirms what is most important to the patient.</td>
</tr>
<tr>
<td>Pre-visit info material passed on from MA/nume or from pt via web pre-visit prep</td>
<td>3b. Uses 1 additional upfront elicitation, patient may indicate completion.</td>
<td>4b. Acknowledges pre-visit info, OR confirms what is most important to the patient</td>
</tr>
<tr>
<td></td>
<td>3c. Does not acknowledge pre-visit info or agrees what is most important to the patient.</td>
<td></td>
</tr>
</tbody>
</table>

**NAME THE PROBLEMS RAISED BY PATIENT OR PHYSICIAN:**

| Maintains efficiency throughout visit | 7a. No shared thinking about priorities, visit structure, or transitions. | 7b. Shared thinking about 1 of the following: priorities, visit structure, problem solving, or transitions. | 7c. Shared thinking about ≥ 1 of the following: priorities, structure, problem solving strategy, transitions. |
| | 8a. Draws off topic, or confused visit structure | 8b. Simple agenda, organized interview | 8c. Tracked multiple topics, organized. |
| Gathering Information | 9a. Uses only closed-ended questions. | 9b. Uses one open ended question and the rest are closed questions. | 9c. Uses more than one open ended question along with closed questions |
| | 10a. No reflecting, clarifying, or summary statements. | 10b. Uses a reflecting, clarifying or summary statement. | 10c. Uses more than one reflecting, clarifying or summarizing statements. |
| Assessing Patient's Perspective on Illness and Health | 11a. Does not acknowledge patient cues | 11b. Acknowledges verbal or non-verbal cues. | 11c. Investigates patient verbal or non-verbal cues. |
| ___ # of clues | 12a. Does not explore or acknowledge patient beliefs, concerns and feelings. | 12b. Responds to patient beliefs, concerns, and feelings. | 12c. Initiates exploration of patient beliefs, concerns and feelings. |
Appendices

C. IRB Forms

1. IRBPHS INITIAL APPLICATION
2. Approval Letter
3. Letter of Support from DNP Committee Chair
4. Letter of Support from UCSF
1. Background and Rationale
    Problem/Population:
    In spite of an international momentum towards evidence-based medical practice (EBP), primary care clinicians (PCC) experience frustration in clinical decision making due to difficult encounters with complex patients. Employing doctor-centered approaches based on a biomedical perspective alone is limiting. However, including biopsychosocial perspectives, such as those employed in patient-centered narrative interviewing, have been shown to improve outcomes because they account for the unique contexts of individual patients and their illness experience and supply information missed when solely parsing data for diseases apart from the context of patients’ personal illness experiences.

    Intervention: UCSF psychiatric nurse practitioner students receive intensive patient-centered narrative interviewing training during their first year of training. Students are then assigned clinical rotations in primary care settings to practice these and other clinical skills. They work directly with primary care clinicians who serve as their preceptors, and they interview and assess patients assigned by that preceptor/clinician. This study evaluates the impact of the biopsychosocial perspective employed by the NP student in the interview and the additional information provided on the clinical decision making process of their preceptor/clinician.
Comparison:
1. Difference in clinician perception of their frustration and their patient’s problem before and after the intervention;
2. Difference in interviewer and clinician perceptions of frustration and patient’s problem before the intervention.

Outcome: Changed PCC perceptions of frustration, patient problem(s) and treatment(s)

2. Description of Sample
The sample consists of licensed primary care clinicians (physicians, nurse practitioners or physician assistants) currently serving as preceptors for UCSF psychiatric nurse practitioner students. The role of the preceptor in this setting is to both provide direct patient care as well as to supervise the clinical training of the NP students. There are no ethnic, age or gender criteria and all subjects are proficient in the English language.

Sites include clinics and hospitals in Sacramento, Marin, San Francisco, Alameda, Contra Costa and San Mateo Counties, including community health centers, hospital-based programs, community-based not-for-profit agencies, multi-specialty medical groups (e.g. Kaiser) and private corporations (e.g. Telecare). UCSF Business Contracts Unit (BCU) maintains current contracts with each of these facilities permitting their clinicians to serve in this precepting capacity.

The applicant is a faculty member at UCSF, and a faculty member and doctoral student at USF but is not an employer or manager of any of the potential subjects. The applicant’s role expectation as clinical faculty with the Psychiatric Nurse Practitioner Program at UCSF includes training students in patient-centered interviewing and other clinical skills, setting up clinical rotations in the sites listed above, and contacting each student’s preceptor to review student expectations and performance and assist that preceptor in student critique, feedback and evaluation. (see attached letter from UCSF Specialty Coordinator)

3. Recruitment Procedure
All current NP student preceptors will be sent an email advising them of student expectations to include opportunities during their April rotations to perform patient-centered narrative interviews. The preceptors will be invited to perform an additional self-assessment in addition to their regular expected precepting roles. They will be explicitly informed that participation is only requested in this additional function and not required. Preceptors who do no answer their emails within one week will receive a follow-up phone call.

4. Subject Consent Process
Patient interviews and subsequent case presentations to their preceptors will be conducted by the NP student at their clinical site without the applicant’s involvement. The applicant will not conduct any face-to-face interviews with patients or the subjects. The subjects will not hand-deliver nor email their assessments or surveys to the applicant. The subject’s agreement via email or phone, after all questions are satisfactorily answered by the applicant, is deemed sufficient consent to participate in the study.
5. Procedures
   a. The sequence of the intervention and data collection includes the following steps:
      1. The subject (preceptor) selects a clinical case using the guidelines provided by the applicant.
      2. The subject (preceptor) completes the Clinician Problem Assessment.
      3. The NP student interviews the patient employing skills learned in the Patient-Centered Narrative Interviewing training sessions.
      4. The NP student completes the Interviewer Problem Assessment.
      5. The NP student presents the case to the subject (preceptor).
      6. The subject (preceptor) completes the Post Case Presentation Survey.
      7. The NP student places the assessments and survey in a sealed envelope addressed to the applicant and places it in his faculty mailbox.
   b. Forms used in this study, and attached to this application, include:
      1. Clinician Problem Assessment
      2. Interviewer Problem Assessment
      3. Post Case Presentation Survey
   c. The intervention is the case presentation by the NP student to their clinician preceptor.
   d. This study does not collect test scores or other data about the human subjects that may already have been collected. Neither patient data nor any form of personal protected information is submitted for this study.

6. Potential Risks to Subjects
   Subjects in this study are not expected to experience emotional discomfort other than that experienced in the regular performance of their job. Subjects are not expected to experience any loss of confidentiality.

7. Minimization of Potential Risk
   A major premise of this study is that clinician frustration in the performance of their role is due to some lack of useful information. Because the study specifically plans to provide such information, it is anticipated that professional frustration will be reduced.

8. Potential Benefits to Subjects
   Subjects participating in this study may experience increased work satisfaction, improvement in patient relationships, and a better understanding of patients’ condition.

9. Costs to Subjects
   There is no monetary cost to any subject. Time and effort involved are considered part of the normal workload in the clinic and the preceptor role in training students.

10. Reimbursements/Compensation to Subjects
    No compensation or reimbursement will be made to any study subject.
11. Confidentiality of Records

No protected or personal health information will be collected in this study. Data collected will be anonymous. Data collection instruments will be kept in a secure locked file cabinet in the applicant’s private office. Completed instruments will have no demographic data. The NP student assigned to each participating site will submit the completed forms to the applicant in an envelope marked only with the applicant’s name.

Signature of Applicant/ Date

Signature of Faculty Advisor*/ Date

*Your signature indicates that you accept responsibility for the research described, including work by students under your supervision. It further attests that you are fully aware of all procedures to be followed, will monitor the research, and will notify the IRB/HS of any significant problems or changes.
IRB Application #10-038 - Approved
USF IRBPHS [irbphs@usfca.edu]

Sent: Wednesday, April 14, 2010 9:34 AM
To: mjterry@usfca.edu
Cc: jfkarshmer@usfca.edu

April 13, 2010

Dear Mr. Terry:

The Institutional Review Board for the Protection of Human Subjects (IRBPHS) at the University of San Francisco (USF) has reviewed your request for human subjects approval regarding your study.

Your application has been approved by the committee (IRBPHS #10-038). Please note the following:

1. Approval expires twelve (12) months from the dated noted above. At that time, if you are still in collecting data from human subjects, you must file a renewal application.

2. Any modifications to the research protocol or changes in instrumentation (including wording of items) must be communicated to the IRBPHS. Re-submission of an application may be required at that time.

3. Any adverse reactions or complications on the part of participants must be reported (in writing) to the IRBPHS within ten (10) working days.

If you have any questions, please contact the IRBPHS at (415) 422-0001.

On behalf of the IRBPHS committee, I wish you much success in your research.

Sincerely,

Terence Patterson, EdD, ABPP
Chair, Institutional Review Board for the Protection of Human Subjects

IRBPHS - University of San Francisco
Counseling Psychology Department
Education Building - Room 017
2130 Fulton Street
San Francisco, CA 94117-1080
(415) 422-0001 (Message)
(415) 422-3528 (Fax)
irbphs@usfca.edu

http://www.usfca.edu/humansubjects/
School of Nursing

March 25, 2010

Terence Paterson, Ed.D.
Christine Yeh, Ph.D.
USF Institutional Review Board for the Protection of Human Subjects Co-Chairs

Dear Colleagues,

I write to express my support for Michael Terry’s study Educational Effectiveness: Impact of Patient-Centered Narrative Interviewing by Psychiatric Nurse Practitioner Students on the Perceptions of Primary Care Clinicians. Mr. Terry is currently a DNP student in the School of Nursing. He will be completing this study as part of an educational effectiveness evaluation of a partnership model of psychiatric nurse practitioners and primary care clinicians working together to manage patients. Mr. Terry will be soliciting participation from primary care clinicians who will have the opportunity to report how working with a PsyNP in primary care impacts their perceptions of patients that may, in turn, influence the manner in which they care for them. As chair of Mr. Terry’s DNP Committee, I support this work and am look forward to working with him on this project.

Please let me know if you have any questions or need additional information. Thanks for your work for the university on the IRBPHS committee and for your thoughtful consideration of this request.

Best Regards,

Judith F. Karshmer, Ph.D., PMHCNS-BC
Dean & Professor
March 28, 2010

Dear Sir or Madam:

This letter is to verify that Michael Terry is an Assistant Clinical Professor at the UCSF School of Nursing in the Advanced Practice Psychiatric Nursing Program. A significant portion of his faculty role is to oversee the clinical preparation of students on and off campus and to work with health care organizations that accept our students for clinical rotations at their sites. More specifically, as clinical faculty in our program, Mr. Terry is authorized to arrange clinical rotations for students; to identify, recruit and support clinician preceptors at clinical sites in the Bay Area and Northern California; and to interface with those clinical sites and clinician preceptors to assure safe and high quality clinical experiences for our students. It is expected that students in these settings will interview, examine and treat patients; and that the clinician preceptors at these sites will train, evaluate and otherwise oversee all aspects of their activity while in their clinical settings.

If you have any questions or need additional information, please contact me at 415-502-4407.

Sincerely,

Beth Phoenix, R.N., Ph.D.
Associate Clinical Professor
Specialty Coordinator, Advanced Practice Psychiatric Nursing Program