The Medical Interview: The Three Function Approach to Relationship Centered Care (Fourth Edition)

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Executive Summary

The Medical Interview: The Three Function Approach, originally published 30 years ago, has been a widely-respected text for generations of health professionals learning the attitudes, concepts and skills of effective interviewing. The fourth edition, retitled, *The Medical Interview: The Three Function Approach to Relationship-Centered Care* (TFA-4) incorporates new evidence that substantially broadens and deepens our understanding of each of the three core interview functions and how they optimize meaning and outcomes. As a result, TFA4 is ideally suited for a rapidly evolving healthcare landscape, including post COVID19 applications.

Earlier versions of Function One focused on the (micro) skills of empathic communication to "respond to patients' emotions" and to "build rapport." In contrast, Function One, **Connect**, now unites these microskills within the broader mindset and heartbeat of professional identity formation. This combination creates optimal conditions for the growth of trusting, caring and mutually satisfying medical relationships. Function Two, which previously identified skills related to "taking" the history, and later on assessing and understanding the patient, is now entitled **Co-Construct.** This reformulation of Function Two envisions patients and clinicians building illness narratives together, in other words, "making" not "taking" the history. And finally, TFA-4 presents an enriched vision of Function Three. While earlier versions discussed educating and motivating or managing patients, Function Three now suggests that patients and clinicians together **Collaborate** on these important tasks. This revision emphasizes cooperation, partnership, shared decision making, shared planning and shared responsibilities, reflecting qualities of evidence-informed optimal medical practice.

TFA-4 supports a fundamental perspective shift in the idea and ideal of "objective" truth in medicine: assessment and management certainty is limited by the probabilistic nature of medical knowledge and mediated by variations in individual perceptions and interpretations.[1] Problem lists and treatment plans are determined through complex interpersonal processes between patients and clinicians (and often with others in the family or the healthcare team). From this vantage point, medical practice and medical

[1] This understanding builds on evolving paradigms of social constructionism, the cognitive sciences and medical decision-making.

conversations are neither doctor-centered nor patient-centered; they are relationship-centered (or "relational/interpersonal").[2] And relationship-centered conversations are fundamentally bidirectional and intersubjective.[3]

The implementation and implications of this perspective shift are far-reaching. It is **humbling** to recognize that there are limitations to objectivity based on probabilistic thinking. At the same time, it is **empowering** to understand that these limitations open diverse pathways towards compassionate healing and improved outcomes.

At its best, the dialogues that **connect** patients and clinicians create a climate of safety, mutual trust, and hope, enabling them to **co-construct** shared understandings of illness and to **collaborate** on management. Optimal outcomes, including patient and physician satisfaction, result from a harmonious interplay of the three functions. Clinicians who understand these functions and utilize the associated skills can find deep meaning, energy, and resilience in their application.

[2] For purposes of this chapter, the authors' use of the terms "relationship-centered," "relational," and "interpersonal" are interchangeable and equivalent. The terms "interpersonal," "bidirectional," and "intersubjective," on the other hand, are treated as separate and are defined and explained in subsequent sections and footnotes.
[3] "Bidirectional" and "intersubjective" are defined in the Project Overview below.

Project Overview

The Medical Interview: The Three Function Approach, originally published 30 years ago, has been a widely-respected text for generations of health professionals learning the attitudes, concepts and skills of effective interviewing. The fourth edition, retitled, *The Medical Interview: The Three Function Approach to Relationship-Centered Care* (TFA-4) incorporates new evidence that substantially broadens and deepens our understanding of each of the three core interview functions and how they optimize meaning and outcomes. As a result, TFA4 is ideally suited for a rapidly evolving healthcare landscape, including post COVID19 applications.

Based on generations of innovative thinking from diverse fields,[4] TFA-4 substantially deepens and broadens each of the three core functions of the medical interview. Earlier versions of Function One focused on the (micro) skills of empathic communication to "respond to patients' emotions" and to "build rapport." In contrast, Function One, **Connect**, now unites these microskills within the broader mindset and heartbeat of professional identity formation, to more explicitly foster development of trusting, caring and mutually satisfying medical relationships. The core microskills for communication of empathy have not changed: reflection, legitimation, exploration, support, partnership, and respect (affirmation). Generations of research and experience confirm that learners can develop proficiency using these micro-skills through a well-described and coherent sequential training process focusing on demonstration, practice of skills (in role play or with patients), feedback and re-practice.

Function Two, which previously identified skills related to "taking" the history, and later on assessing and understanding the patient, is now entitled **Co-Construct.** This reformulation of Function Two envisions patients and clinicians building illness narratives together, in other words, "making" not "taking" the history. To co-construct the illness narrative, clinicians utilize the microskills of questioning (open-ended

[4] The clinical foundations of the approach we embrace were described by early pioneers of the "bio-psycho-social" model of illness in the 1970s, (George Engel and others), supported by landslides of empirical documentation, and later, by theoretical extensions including: "patient, person, and family-centered care; "the patient-centered medical home; " "humanistic" care; "narrative medicine;" and "relationship-centered care." About the same time that the clinician-patient relationship came center stage, a convergence of creative philosophical, sociological, and economic thinking (1960-1980) began challenging traditional scientific notions of "objectivity" in the world of physical "reality," in general, and more specifically, in the world of medical care. Critical thinkers like Peter Berger and Thomas Luckman (sociology), Michael Polanyi and Thomas Kuhn (history and philosophy of science), Victor Fuchs (economics), and others, proposed concepts such as social construction, co-participation, co-construction, and co-production to describe how social processes fundamentally shape our perceptions and understanding of external physical "realities" - and most especially, for our purposes, the interactions between clinicians and patients in which topics like disease, illness, and wellness are discussed. Advances in the cognitive sciences and clinical decision-making during the same period (1960-2000) informed our understanding of individual differences in perceiving and interpreting stimuli ("reality"), while acknowledging the importance of probabilistic thinking that qualifies certainty for medical diagnosis, treatment, and management.

questioning and the open-to-closed cone), active listening, facilitation, directing, checking, and summarizing, to establish a "chronology of the present illness (CPI)" (also called the "history of the present illness (HPI)"). To support diagnostic reasoning, clinical inference, and biopsychosocial understanding, clinicians work toward developing the AIHPI ("all inclusive HPI"). The AIHPI includes what has been more recently called the "patient experience" (or "What Matters to You, WMTY") as well as the patient's perspectives (ICE - Ideas, Concerns, and Expectations about the illness), the patient's premorbid and evolving life context through the illness experience and the impact of the illness on the patient's quality of life (including psychological, social, and sexual functioning).

And finally, TFA-4 presents an enriched vision of Function Three. While earlier versions discussed educating and motivating or managing patients, Function Three now suggests that patients and clinicians together **Collaborate** on these important tasks. This revision emphasizes cooperation, partnership, shared decision making, shared planning and shared responsibilities, reflecting qualities of evidence-informed optimal medical practice. Specifically, Function Three includes best practices for patient education and shared decision-making, as well as the eight core competencies of Brief Action Planning (BAP), a highly structured, versatile, stepped care Motivational Interviewing (Adherent) tool designed to efficiently help patients change and support self-management for health and well-being.

TFA-4 supports a fundamental perspective shift in the idea and ideal of "objective" truth in medicine: assessment and management certainty is limited by the probabilistic nature of medical knowledge and mediated by variations in individual perceptions and interpretations.[5] Problem lists and treatment plans are determined through complex interpersonal processes between patients and clinicians (and often with others in the family or the healthcare team). From this vantage point, medical practice and medical conversations are neither doctor-centered nor patient-centered; they are relationship-centered (or "relational/interpersonal").[6] And relationship-centered conversations are fundamentally bidirectional and inter-subjective.

What does it mean to assert that the medical dialogue and medical care is **relationship-centered** (relational/interpersonal), as well as **bidirectional** and **intersubjective**?

[5] This understanding builds on evolving paradigms of social constructionism, the cognitive sciences and medical decision-making.

[6] For the purposes of this work, the authors use the terms "relationship-centered," "relational," and "interpersonal" as inter-changeable and equivalent.

Relational [7] suggests that unfolding interpersonal processes between patients and clinicians fundamentally influence the story of the illness (narrative) and treatment planning.

Bidirectional[8] further characterizes the nature of interpersonal clinical conversations suggesting that clinicians and patients continuously influence and shape each other's contributions to the emerging illness narrative and management plans.[9] And finally;

Intersubjective[10] implies that interpersonal, bidirectional conversations are best understood as influenced by recurring cycles of a patient's subjective/personal symptoms and suffering and processed through the lens of a clinicians' subjective/personal interpretations.[11]

The implementation and implications of this perspective shift are far-reaching. It is **humbling** to recognize that there are limitations to objectivity based on probabilistic thinking. At the same time, it is **empowering** to understand that these limitations open diverse pathways towards compassionate healing and improved outcomes.

It is important to understand that these bidirectional and intersubjective limitations to certainty do not make medical science "subjective." In fact, awareness of these elements makes best medical practice more, not less "scientific."[12]

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[7] "Relational" is defined (Merriam-Webster) as "the relationship between two or more things."

[8] "Bidirectional" is defined (Merriam-Webster) as "involving, moving,, or taking place in two usually opposite directions."

[9] Self and situational awareness, foundations of physician resilience and patient safety, depend upon a meaningful understanding of the bidirectional nature of the clinical conversation.

[10] "Intersubjective"is defined (Merriam-Webster) as "occurring between separate conscious minds."

[11] We introduce the concept subjective/"personal" as an alternative to an unobtainable "objective/a-perspectival" reality. (cf Daston L, Galison P: Objectivity, Zone Books 2007.) "Objective" is defined as *"facts or conditions as perceived without distortion by personal feelings, prejudices, or interpretations"* (Merriam-Webster). Though clinicians strive for "objectivity," we believe that attaining "objectivity" (independent of one's own perspectives) in the medical dialogue is rarely possible. But does that make all dialogue "subjective"? Not exactly. We follow the suggestion of Michael Polanyi, in his book Personal Knowledge: we *"know more than we can say,"* ("tacit" knowledge). Facts or conditions cannot be entirely "objective," (that is free of individuals' perspectives), but that doesn't make them entirely "subjective." (Medical) Facts or conditions are grounded in "personal knowledge," that are substantive and meaningful shared and accepted medical "realities."

[12] Earlier views of "scientific" medical practice, sometimes called "the biomedical model" were based on the philosophical approach of "reductionism" and "logical positivism." From this approach, medical problems were seen as riddles to be "discovered," much like identifying a specimen under the microscope. The problem with the biomedical approach is that clinician's understanding of the medical suffering of a human being is just not reducible or even analogous to recognizing the microscopic pattern of a microbial specimen. Human beings are more than specimens, they are thinking, feeling, reacting beings who influence and are influenced by those with whom they interact, including clinicians and the clinical team.

This is both descriptive and proscriptive. It defines best medical practice as it currently operates as well as describing best practice for how it "should be." This view fully aligns with current concepts of narrative medicine, patient-centered medicine, and humanistic medical care, as well as the movement of "Patient Experience" ("What Matters to You, WMTY"). Understanding the role of bidirectional intersubjectivity in providing care is an important building block in integrating self-awareness into routine practice. Self-awareness, in turn, is a gateway to establishing one's professional identity and maintaining relationships (with patients as well as colleagues).

At its best, the dialogues that **connect** patients and clinicians create a climate of safety, mutual trust, and hope, enabling them to **co-construct** shared understandings of illness and **collaborate** on management. Optimal outcomes, including patient and physician satisfaction, result from a harmonious interplay of the three functions. Clinicians who understand these functions and utilize the associated skills can find deep meaning, energy, and resilience in their application.

In terms of application, TFA-4 aims to address the learning needs of beginners, as well as the more subtle and complex needs of experienced clinicians across a broad range of practitioners including: physicians, psychologists, nurse practitioners, physician's assistants, dentists, nurses, physical therapists, social workers, dieticians, and all allied health professionals. Updated and revised chapters cover core skills as well as advanced applications. Entirely new chapters discuss moral injury (burn-out), the electronic medical record, professionalism, and development of professional identities. Professional identity formation includes mindful medical practice as well as the spirit of motivational interviewing. Each of the revised and new chapters of TFA-4 align with the reformulated conceptualization of the three functions, Connect, Co-Construct, and Collaborate, and describe skills most useful for efficient, effective and caring medical practice.

In sum, TFA-4 promises to deliver the most up-to-date thinking, evidence, and pedagogy; features that made earlier editions, themselves, classics. And most importantly, TFA-4 aims to provide an inspiring vision with sufficient tools for building excellence in relationship-centered medical care along with passion for compassion.