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Comments

PSYCHIATRISTS ALSO NEED INTERVIEW TRAINING

Much of the psychiatric morbidity which presents to general practitioners remains hidden, especially when the patient offers somatic symptoms or is already suffering from an established illness (Goldberg and Blackwell, 1970). This failure to recognize patients who need psychiatric help stems largely from inadequacies in the practitioner's interviewing skills (Goldberg and Huxley, 1980). Deficiencies in the content of their consultations which correlate with low recognition include the failure to screen for the possibility of psychiatric symptoms and the absence of any questions about the patient's family. Interviewing skills associated with a high detection rate include the establishing and maintenance of good eye contact, clarification of the patients' presenting complaints, picking up verbal and non-verbal cues, using open questions, and the ability to control the course of the interview.

Studies of physically-ill patients who are being treated or followed up by a general hospital have also found that those who develop psychiatric problems are not usually recognized or helped appropriately (Maguire *et al*, 1978a). As in the general practice studies, deficiencies in interviewing skills are mainly responsible. Principal among these are the failure to enquire about the impact of the physical illness on the patient's psychological and social functioning and the missing of major verbal or non-verbal cues which patients give about their psychological problems. It is important, therefore, to consider why doctors are deficient in these essential skills, especially as there is evidence that they do not improve with experience. For example, irrespective of experience, general practitioners are found to use few empathic statements, avoid eye contact and do not talk about more personal issues. They end consultations poorly and pay little heed to psychological and social issues (Verby *et al*, 1979).

Traditionally, doctors learn to interview by taking histories from patients and reporting back what they found to a tutor within a seminar, ward round or clinic. The tutor usually focusses on the facts obtained and pays little attention to how the student or doctor interviewed. Nor is it likely that the tutor will have watched the interview or a video-recording of it. Consequently both teachers and those being trained remain ignorant of any deficiencies and can continue to argue that traditional methods of training are effective.

This neglect of interviewing techniques is commonly compounded by the printed handouts which most students are given. These contain lists of the data to be obtained, but rarely include any detailed account of the relevant techniques or how to begin and end an interview. Even so, many teachers are not concerned about these inadequacies in conventional training methods. They believe that students and doctors best learn interviewing skills by watching expert clinicians at work. They usually regard themselves as suitably expert, even when they have only been trained by the very same traditional methods which led to the students' and doctors' skills being deficient.

Such teachers ignore the considerable body of evidence that shows that traditional methods of clinical training are ineffective (Sanson-Fisher and Maguire, 1980). They also fail to realise that the modelling influences in which they put their faith are unpredictable if no checks are made by observation of performance to confirm that desirable rather than undesirable behaviours have been acquired. Their complacency may explain, at least in part, why so few are prepared to change their methods of training.

Yet, it has been established that training which includes the provision of handouts or videotapes which describe not only the data to be obtained but also the techniques which should be used, practice with simulated or real patients under controlled conditions, feedback of performance by videotape or audiotape replay, and discussion with a tutor do lead to the acquisition of the key skills and are much superior to traditional methods (Maguire *et al*, 1978b; Goldberg *et al*, 1980). This training is just as effective whether it is carried out with individual students or in small groups of four students. It requires only an hour to an hour and a half a week for each group. It should, therefore, be feasible for most clinical teachers, especially as audio-cassette recorders are now cheaper and available.

Despite this, the adoption of these feedback methods has been patchy. When it has occurred, this has usually been within departments of general practice and psychiatry. Efforts have been concentrated on undergraduates rather than postgraduates.

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Consequently, most trainees in psychiatry are much more deficient in their interviewing skills than is realized. Even so, the response within psychiatry has been slow. Many teachers still rely on the time-honoured but ineffective apprenticeship method.

Their reluctance to change is hard to understand since the abilities to interview and empathise are central to the practice of psychiatry. Moreover, better training methods would improve the standard of psychiatric practice and the ability of non-psychiatrists to recognize those patients who develop psychiatric illness (Maguire *et al*, 1980).

If psychiatrists are unwilling to profess the importance of these skills and ensure that medical students and psychiatrists in training acquire them, they cannot expect other clinicians to accept that they possess skills worthy of respect or curriculum time.

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