Teaching the Psychosocial Aspects of Care in the Clinical Setting: Practical Recommendations

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Abstract

Communication skills and the psychosocial dimensions of patient care are increasingly taught in medical schools and generalist residency programs. Evidence suggests they are not reinforced or optimally implemented in clinical training. The authors present the product of an iterative process that was part of a national faculty development program and involved both experts and generalist teachers concerning teaching psychosocial medicine while precepting medical students and residents in clinical settings. Using scientific evidence, educational theory, and experience, the authors developed recommendations, presented them in workshops, and revised them based on input from other experts and teachers, who gave feedback and added suggestions. The results are practical, expert consensus recommendations for clinical preceptors on how to teach and reinforce learning in this area. General skills to use in preparing the trainee for improved psychosocial care are organized into the mnemonic "CAARE MORE": *C*onnect personally with the trainee; *A*sk psychosocial questions and *A*ssess the trainee's knowledge/attitudes/skills/behaviors; *R*ole model desired attitudes/skills/behaviors; create a safe, supportive, enjoyable learning *E*nvironment; formulate specific *M*anagement strategies regarding psychosocial issues; *O*bserve the trainee's affect and behavior; *R*eflect and provide feedback on doctor–patient and preceptor-trainee interactions; and provide *E*ducational resources and best *E*vidence. The preceptor–trainee teaching skills that are recommended parallel good doctor–patient interaction skills. They can be used during both preceptor–trainee and preceptor–trainee–patient encounters. Important common psychosocial situations that need to be managed in patients include substance abuse, depression, anxiety, somatoform disorder, physical and sexual abuse, and posttraumatic stress disorder. For these problems, where high-level evidence exists, specific psychosocial questions for screening and case finding are provided.

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Professionalism and humanistic communication skills are core competencies for physicians.[1–3] Increasingly, residency programs will be required to document that their graduates attain these competencies.[1] Effective methods have been developed for teaching humanistic communication skills and approaches to patient care[4–8] and are used in many medical schools and residency programs.[4,7,9] However, the knowledge, skills and attitudes taught in targeted curricula are often neither modeled nor reinforced in clinical settings,[10–12] and humanistic attitudes and behaviors may become attenuated or extinguished.[12–15] As part of this problem, well-meaning clinical preceptors may fail to recognize opportunities for teaching the psychosocial aspects of patient care,[16] and may inadvertently model[12,17,18] or fail to address[19] negative attitudes and behaviors.

With these issues in mind, we developed the recommendations proposed in this article, after refining them with other experts and with generalist teachers. The recommendations are designed to help preceptors teach, reinforce, and promote the application of humanistic approaches in the care of patients in busy clinical settings. We use the shorthand term "TIPS" for these recommendations; we use it both in the normal sense of the word *tips*, as items of advice, and as an acronym to connote the context for that advice, *t*eaching *i*n the *p*atient *s*etting. *Humanistic care* is defined as being patient-centered and integrating the psychosocial with the biomedical aspects of care. Those who practice humanistic care demonstrate interest in and respect for individual patients and address their values, concerns, and emotional, social, cultural and spiritual needs. Such care improves information- gathering and promotes accurate diagnoses,[4,20–23] increases patients,[4,24–26] and physicians,[27–29] satisfaction, decreases the likelihood of malpractice litigation,[30] and improves important clinical outcomes such as adherence with medication.[24,31–33] It addresses psychosocial problems, which are common in medical patients, frequently go unrecognized, are associated with increased medical utilization, and affect the management and outcomes of patients' medical problems.[4,34]

Developing the Recommendations

We developed these psychosocial TIPS from 2001 to 2004 as part of the National Faculty Development Program for General Internal Medicine, sponsored by the U.S. Public Health Service Health Resources and Services Administration.[35] The planning group for this collaborative effort, termed GIMGEL (the General Internal Medicine Generalist Educational Leadership Group), included representatives from several major organizations representing internal medicine.* TIPS were designed to provide practical guidance for generalist outpatient preceptors to teach trainees (both medical students and residents) and reinforce previous learning in key content areas in which the preceptors may not be expert: cost–effectiveness, end-of-life care, evidence-based medicine (EBM), geriatrics, prevention, and psychosocial aspects of care. Development teams consisted of one to two GIMGEL members plus one or more outside experts in the content area. Each TIPS recommendation was presented as a work-in-progress workshop (held twice) at the program's final national conference, and subsequently revised based upon feedback from workshop participants. The psychosocial TIPS we present here underwent additional revisions based upon input from participants at workshops that were subsequently presented at national meetings of the Society of General Internal Medicine and the American College of Physicians–American Society of Internal Medicine. Final revisions were made during conference calls of the authors, which include two expert GIMGEL members (WB, DK), two outside experts (ML, WL), and three expert participants (DB, MF, JJ) from the initial workshops held at the program's final national conference. The final recommendations represent the consensus of the authors and include input from content experts, educational experts, and practicing preceptors.

*The American College of Physicians–American Society of Internal Medicine (ACP–ASIM), the Association of Program Directors in Internal Medicine (APDIM), the Association of Professors of Medicine (APM), the Association of Subspecialty Professors (ASP), the Clerkship Directors in Internal Medicine (CDIM), and the Society of General Internal Medicine (SGIM).

Challenges, Barriers to Teaching Humanistic Care

Preceptors in a busy clinical setting face a number of challenges and barriers to helping trainees use appropriate communication skills and address the psychosocial needs of patients. Some barriers reside within patients, others within the preceptors or residents, yet others within the medical care system.

- Patients may reduce the recognition of psychosocial issues by presenting with somatic rather than emotional complaints[36–38] or resist psychosocial diagnoses by attributing symptoms to physical causes.[39]
- Preceptors and residents may be concerned about potential patient stigma,[36,40] fear they are opening a Pandora's box the contents of which they cannot adequately address,[40,41] believe that psychosocial management is burdensome,[42] have inadequate knowledge about diagnostic criteria or treatment options,[43–45] lack psychosocial orientation,[46] have practice styles not conducive to psychosocial talk,[47,48] or lack insight into patients' different cultural presentations of psychosocial issues.[49]
- As for the systems barriers, the average ambulatory teaching encounter is short, between four to 15 minutes in length,[50] and physicians face an ever-expanding slate of topics to cover with patients. Other systems barriers include productivity pressures, limitations of third-party coverage, restrictions on specialist, drug, and psychotherapeutic care,[36,40] lack of a systematic method for detecting and managing patients with psychosocial problems,[51] and inadequate continuity.[36,40]

TIPS: The Preceptor's Toolbox

In this section, we present psychosocial TIPS—recommendations for teaching a humanistic approach while precepting patient care—and also outline uses of TIPS for specific situations.

TIPS for teaching a humanistic approach

Because of the challenges to teaching a humanistic approach while precepting, the preceptor needs to use a variety of teaching methods. Some of these methods are designed to raise awareness and change attitudes (asking, promoting reflection, role modeling), some to teach skills (supervised practice, observation and feedback, role play), some to reinforce behaviors (observation, feedback), and others to fill in knowledge gaps (brief didactics, discussion, mini-assignments, readings).[52] Accordingly, the TIPS may be viewed as a toolbox, the contents of which should be used selectively depending on patient and trainee needs. Table 1 lists the TIPS; each of them is bolded, followed by clarifications and examples, with comments in the right-hand column. The TIPS are shown in a sequence that produces a mnemonic, CAARE MORE, for ease of recall.

The psychosocial aspects of care can be taught both during the time a trainee presents and discusses a patient with a preceptor outside of the patient's room and also in the room with the patient and trainee. As can be seen in the table, many of the teaching skills recommended in interacting with the trainee are paralleled by the communications skills that are desired in interacting with the patient. The TIPS focus on establishing learner–centered and patient–centered safe, and helpful preceptor–trainee–patient relationships. They are directed to raising awareness of and attention to the humanistic needs of both trainees and patients. Because trainee–patient interactions can mirror supervisor–trainee interactions, addressing this "parallel process" is a recognized component of psychotherapy supervision.[53] It has been also been described in precepting family medicine residents.[54,55]

Because the human dimensions of care are part of every doctor–patient interaction, some of these TIPS are applicable to almost every encounter. One or more teaching methods may be used in a given teaching encounter, such as picking up on a patient cue or asking the trainee about the patient's concerns, as shown in the following example. (The applicable TIPS are italicized within parentheses in this example and the one that follows.)

Example 1

With the Patient

> After the resident explains to the patient that he will need to be on Coumadin for anticoagulation, the patient hesitates, then says, "I guess that will be OK." (*TIP: Observe patient's affect or other nonverbal or verbal clues.)*

Table 1

TIPS for Teaching a Humanistic Approach While Precepting Patient Care

TIPS for the preceptor–trainee and the preceptor–trainee–patient interactions*†	Comments
Connect with the trainee (and patient). • Greet trainee (patient) warmly. • Get to know trainee (patient) as a person. • Incorporate past knowledge of trainee (patient) as a person into today's interaction. • Achieve and communicate accurate empathy with trainee (patient). • Demonstrate partnership with trainee (patient) and respect for trainee's role as care provider	By connecting with trainees and patients as persons, understanding, respect, and trust can be enhanced. Teaching and management strategies can be tailored to individual characteristics of the trainee or patient.
Assess trainee's (and patient's) knowledge, thinking, attitudes, feelings, and skills. • Listen to trainee's presentations. • Ask for the trainee's assessment of the patient. • Assess trainee's skills using impromptu role-play. • (Interview patient jointly. Clarify in advance goals/process/roles when seeing patient together, including who will take the lead in talking to the patient.) • (Listen to patient.) • (Assess trainee's skills using observation.)	Assessment permits teaching based on the trainee's needs and care based on the patient's needs.
Ask psychosocial questions.‡ This can be done during both preceptor–trainee and preceptor–trainee–patient interactions. Some helpful questions are: • What are the patient's feelings? • What are the patient's concerns? • What are the patient's expectations? • What does the patient think is going on? • What stressors are present in the patient's life? • What are the patient's family, social support? • What are the impacts of psychosocial issues on treatment, health outcomes? • What are the patient's health beliefs? • What are the patient's spiritual beliefs? • What can and cannot be changed? • What are the patient's feelings regarding the management plan?	Selectively asking questions about psychosocial issues raises awareness of these issues for the trainee, and adds to the assessment of the patient. Because the patient's report on these issues is more likely to be valid than the trainee's report, precepting in the presence of the patient can be especially important here. Asking psychosocially oriented questions of trainees can also help the preceptor assess the trainee (e.g., What are trainee's feelings, assumptions, concerns, expectations regarding the interaction. What stressors that are in the trainee's life may be affecting the interaction?).
Role model important behaviors, such as: • Enjoyment in understanding and connecting with trainees and patients • Empathy • Respect • Appropriate self-disclosure • Good nonverbal skills • Social amenities • Facilitation of both the affective and cognitive aspects of learning • Addressing psychosocial issues and patient concerns	These behaviors can be modeled during both preceptor–trainee and preceptor–trainee–patient interactions. During the latter, by having the trainee observe specific preceptor actions and then discuss the observations, the preceptor can convert role-modeling from a passive to an active learning experience for the trainee. This enables the preceptor to raise the trainee's awareness of how these traits can be expressed as well as to assess the impact of role modeling on the trainee.
Environment. Establish a safe, supportive, enjoyable learning environment. (Role model or have trainee practice developing a safe, supportive, enjoyable doctor–patient relationship.)	A safe and enjoyable learning environment can be encouraged by seeking understanding, demonstrating respect, being supportive, avoiding hurtful criticism, appropriately self-disclosing one's own failures/challenges/successes, and creating positive challenges for the trainee. Such an environment promotes the trainee's reflection, self-awareness, and willingness to change/try new approaches. (A safe supportive, enjoyable doctor–patient relationship encourages patient trust in the doctor, and patient disclosure of sensitive information.)

(*Table continues*)

Table 1
(*Continued*)

TIPS for the preceptor-trainee and the preceptor-trainee-patient interactions*†	Comments
Manage. Integrate communication skills and the management of psychosocial issues into ongoing care. • Discuss patient education and involving the patient in decisions and management plan (role model and practice methods). • When appropriate, formulate and pursue specific psychosocial diagnoses (see Tables 2 and 3‡). • Teach methods for addressing psychosocial problems. • Be practical: focus on psychosocial issues that are likely to affect health outcomes; help trainee deal with time issues (role model or have trainee practice).	The future behavior of trainees is most likely to be influenced when the trainees experiences the impact of applying doctor–patient communication skills and psychosocial assessment to the successful management of patients' care.
Observe. Observe trainee's affect and other non-verbal or verbal clues; observe trainee's skills using impromptu role plays. (During trainee's interaction with patient: observe trainee's skills; observe trainee's and patient's affect, other non-verbal and verbal clues.)	Such observations are a basis for accurate assessment (see above), reflection, and feedback (see below). Supervised practice, with observation and feedback, is the most important method for teaching and reinforcing skills.
Reflect, discuss, and provide feedback. • Reflect, discuss, and provide feedback on doctor-patient interaction, on trainee's assessment and thinking, affect, skills and behaviors. • Acknowledge positive humanistic behaviors. • (Involve the patient by asking for his or her perspective on the interaction.)	Reflection on one's knowledge, attitudes, feeling, or performance brings the relevant dimension to conscious recognition. Such recognition, discussed in a safe learning environment with active trainee participation, encourages change and personal/professional growth. Positive feedback can help reinforce and enhance humanistic behaviors. (A parallel process exists in helping the patient change health-related behaviors.)
Evidence/Education. • Provide readings, mini-assignments, and scientific support that address knowledge gaps. • Summarize main learning point(s). • (Provide patient with appropriate reading, learning, and monitoring aids.)	Providing information and cognitive supports enables cognitive, attitudinal, and behavioral change.

* Activities carried out when the precepting takes place in the presence of the patient are noted in parentheses. There are striking parallels between the preceptor–trainee relationship and the doctor–patient relationship.

† Frequently, a family member (or family member substitute) may be present during this interaction. Ascertaining the patient's preference about the accompanying person's presence, and respectfully including the accompanying person, while supporting the privacy of the patient, can be achieved in the context of these TIPS. In these situations, a humanistic approach to the family member can also be taught.

‡ Tables 2 and 3 present specific psychosocial questions, relevant to implementing TIPS, that are helpful in eliciting sensitive information (sexual history, literacy, health-related behaviors) and pursuing diagnoses of suspected, commonly encountered psychosocial conditions.

The resident goes on to explain other aspects of the management plan and write the new prescription for Coumadin.

Preceptor to patient, at an appropriate time in the three-way interaction. "I wonder if you have some reservations or questions about taking Coumadin?" (*TIP: Role model asking psychosocial questions: What are the patient concerns? What are the patient feelings regarding the management plan?)*

In the Conference Room

After leaving the exam room, the preceptor asks the resident, "Why do you think I asked the patient the question about whether he had reservations or questions? (*TIP: Reflect, discuss, and provide feedback on doctor–patient–attending interaction, summarize main learning points.)*

If the trainee had picked up on the patient's hesitation and asked the same question as the preceptor, the preceptor could have provided positive feedback, such as by saying to the trainee, "I was impressed the way you picked up on the patient's hesitation, and asked him about any reservations or concerns. By addressing his concerns you probably increased his chances of taking the Coumadin. (*TIP: Acknowledge positive humanistic behaviors.)*

Not infrequently, patient concerns or psychosocial issues assume a dominant role in a patient-physician interaction. When this is the case, the TIPS may be used more extensively, as illustrated in the following example.

Example 2†

In the Conference Room

Resident: This is a quick case. She's a 43-year-old women who comes in for some GI complaints. She had the same problems a month ago. There are several complaints, no particular pattern: some stomach gas and acid, some rumbling, a little distention, some constipation, but no blood in the stool and negative hemoccult. Really no past history or anything on review of systems. Exam was normal. I gave her some Zantac and some Colace. Basically she just needs reassurance.

†Adapted from Brady D, Schultz L, Spell N, Branch WT Jr. Iterative method for learning skills as an efficient outpatient teacher. Am J Med Sci. 2002;323:124-9. Used with permission.

Preceptor: So, what do you think is going on with the patient? (*TIP: Assess trainee's knowledge and thinking, be learner centered.*)

Resident: Probably nothing (said a little disdainfully). Most likely irritable bowel syndrome. She has had no weight loss, bleeding, fever, night sweats, nor steady pain. I think she has had some episodes of loose bowels in the past, but most of the symptoms now seem related to dyspepsia. So I gave her Zantac. (*TIP: Observe trainee's affect or other nonverbal or verbal clues.*)

Preceptor (Sensing something more is going on with the patient): She has been in twice with these complaints. What does she think she has? (*TIP: Ask psychosocial questions, e.g., What are the patient's concerns?*)

Resident: Actually, I am not sure. She seems a little overly anxious for someone with just these symptoms. I didn't think to ask her what she thought it might be.

Preceptor: Sometimes asking the patient about their thoughts and concerns is a good way to start when you're not sure what may be worrying a patient. (*TIP: Be practical: focus on psychosocial issues that are likely to affect health outcomes; help trainee deal with time issues.*)

Preceptor: You seem to have a pretty good history of the patient's symptoms, and a negative physical examination, so when we go in let's concentrate on trying to find out what she is concerned about. Would you like me to demonstrate or would you like to try yourself? (*TIPS: Provide feedback. Interview patient jointly, being patient- centered. Clarify in advance goals/process/roles when seeing patient together, including who will take the lead in talking to the patient.*)

Resident: Why don't you demonstrate?

With the Patient

Preceptor: So, Mrs. Smith, Dr. Jones just filled me in on your symptoms and findings. He tells me you have some acid burning sensations in your stomach for about a month, along with rumbling noises, fullness, and constipation. But importantly, he did not find any abnormalities on physical examination or any history of loss of weight or blood in the bowel movements that might be of concern to us. Have I gotten that right?

Patient: Yes, that's pretty much what I have been experiencing. I was wondering about having further tests, though.

Preceptor: It would help me to know what concerns you have about these symptoms? (*TIP: Assess patient jointly. Role model or have trainee practice asking psychosocial questions to ascertain what are the patient concerns.*)

Patient: Well, doctor, the truth is, I have had these symptoms for more than just a month. I've had some loose bowel moments and some constipation, and I read that a change in bowel movements might be a sign of cancer. My father died of colon cancer ten years ago and so it's been a concern of mine.

Preceptor: Your concern seems very understandable to me in light of that history, although I do not think that the symptoms you describe are particularly suggestive of colon cancer. (*TIP: Role model the addressing of psychosocial issues and patient concerns.*) We often call these symptoms irritable bowel, a type of symptom that occurs when the bowel itself is normal, but is experiencing spasm related to changes in the diet, or even stress. Are you under any stress? (*TIP: Role model or have trainee practice psychosocial questioning skills: What stressors are present in the patient's life?*)

Patient: Well, I have been worried about my job. There have been a lot of layoffs at the plant, and I haven't been sleeping well. But I still wonder about the change in bowel movements.

Preceptor: The types of changes you are experiencing are more typical of irritable bowel, and the stress you are currently under would explain why it is worse at present. Nevertheless, you are understandably concerned about your family history. There are criteria for screening for colon cancer in folks with family histories of colon cancer. (*TIP: Role model empathy and respect. Role model or practice patient education, negotiate management plan with patient and resident together.*) How old was your father when he developed colon cancer?

Patient: He was 72.

Preceptor: Well, that means that we would normally not start colonoscopy, without any evidence of blood in the stool, until you are 50. Let me get Dr. Jones back into the conversation, because he may have an opinion on this as well, and now that we know your concern about colon cancer, we want to set up a screening program that we can all agree upon and that will detect any abnormalities before they progress to cancer. (*TIP: Demonstrate partnership with the trainee and/or patient, respect for trainee's role as care provider. TIP: Involve patient in decision and management plan. TIP: Integrate communication skills and the management of psychosocial issues into management plan.*)

In the Conference Room after Leaving the Exam Room

Preceptor to Trainee: So, what did we learn from that interaction? (The preceptor and trainee discuss the need to find out patients' hidden concerns, the need to integrate psychosocial issues into the management plan.) (*TIPS: Reflect on the doctor–patient interaction, summarize main learning points.*)

In both examples, the preceptor focused on psychosocial issues relevant to health outcomes and used the toolbox selectively. Even though teaching the psychosocial aspects of patient care may have taken more time in the second than in the first example, both interactions occurred within the time frame of a precepting encounter, provided meaningful learning, and probably improved the outcomes of the visit.

TIPS for specific situations

To meet the psychosocial needs of their patients, physicians must be aware of these needs. Preceptors can teach and reinforce data gathering skills that identify psychosocial needs. Tables 2 and 3 list specific psychosocial questions, relevant to implementing TIPS, that are helpful in eliciting sensitive information (sexual history, literacy, health-related behaviors) and pursuing diagnoses of suspected, commonly encountered psychosocial conditions. Where available, the evidence base is summarized and cited.

Management of a psychosocial condition will depend on the specific diagnosis. In addition to treatment directed to the specific disorder, patients often benefit, regardless of the diagnosis, from emotional support and counseling related to psychosocial stresses.[57] Treatment, support, and counseling may be provided by the primary care provider or by referring the patient to a mental health professional or religious advisor, depending on the patient's condition and preferences, the provider's expertise, and the level of rapport, trust and respect in the provider–patient relationship. By role modeling or facilitating the trainee's recognition and management of specific psychosocial conditions, the preceptor is promoting an integrated, humanistic approach to patient care.

Patient education and promoting behavioral change are parts of most doctor–patient interactions, and are discussed in detail in other publications.[58] These activities involve assessing the patient's needs (including literacy level[59,60]), health-related behaviors, and adherence to prescribed regimens; targeting the educational intervention to the patient's needs and interests; prioritizing and lim-

Table 2

Questions for Pursuing Specific Psychosocial Hypotheses and Content, When Indicated*

Psychosocial issue	Initial screening questions or observation	Follow-up options for a positive screen (see Table 3 for details of psychosocial screening tests)
Alcoholism or alcohol problem†	Do you drink alcohol?	For a "Yes" answer, follow up with one of the following: • CAGE (score ≥ 2, sensitivity 40–95%, specificity 70–105%)[88–92] • TWEAK (score ≥ 3, sensitivity 60–95%, specificity 75–97% may be better than CAGE in women)[88–90] • AUDIT (score ≥ 8, sensitivity 60–105%, specificity 75–99%, may be better for detecting problem drinkers before dependence or abuse develops)[88,90,93–97] • AUDIT-C (score ≥ 5, sensitivity 65–95%, specificity 75–90%)[94,95] • AUDIT-3 (score ≥ 1, sensitivity 75–90%, specificity 65–85%), (score ≥ 2, sensitivity 55–75%, specificity 85–95%)[94,95]
Anxiety†	During the past month, have you often been bothered by • "nerves" or feeling anxious or on edge? • worrying about a lot of different things?[98] During the past month, have you had an anxiety attack (suddenly feeling fear or panic)?[98]	For a "Yes" answer to either question, follow up with formal questions using the PRIME-MD or PRIME-MD Patient Health Questionnaire (PHQ) (sensitivity 63–69%, specificity 90–97% for any anxiety disorder; sensitivity 57–81%, specificity 99% for panic disorder; sensitivity 57%, specificity 91% for generalized anxiety disorder).[98,99]
Depression†	During the past month have you often been bothered by • feeling down, depressed, or hopeless? • having little interest or pleasure in doing things?[98]	"Yes" to either screening question has a sensitivity of 96% and specificity of 57% for major depression.[100] Follow up with Patient Health Questionnaire-9 (PHQ-9) (score ≥ 10, sensitivity 88%, specificity 88% for major depression) (score 5–9 mild symptoms; 10–14, moderate; 15–19 moderately severe; ≥ 20 severe)[99] (score > 2 on ≥ 5 items, sensitivity 73%, specificity 105% for major depression).[99]
Domestic violence	"At any time has a partner or close person hit, kicked, or otherwise hurt or threatened you?"	For a "Yes" answer, follow up using SAFE questions (Stress/Safety, Afraid/Abused, Friends/Family, Emergency Plan).[102,103]
Health-related behaviors, adherence to/compliance with treatment plans	"What are you doing for your [name of health problem]?" "How is it going with your medicines, . . . diet, . . . exercise?" "Any problems, side effects, or challenges?" "What medicines are you taking? How are you taking them?"	Follow up on clues, using open-ended, facilitative, supportive, nonjudgmental, yet detailed and specific questions, to achieve an understanding of the patient's current health behaviors. Specifically ask about health behaviors on the day of and the day preceding the visit (some diabetic patients routinely omit all medications, including insulin, at the time of a morning visit; 24-hour recalls are more accurate than general reports, which tend to be idealized).[58]
Low health literacy	"How far did you go in school?"‡ "A lot of people have trouble reading things they get from the doctor because of all the medical words. Is it hard for you to read the things you get here at the hospital?"‡	A positive response to the second question or failure to complete high school should raise suspicion, as should frequently missed appointments, failure to know names of medications, "I forgot my glasses," or always coming with someone else who serves as a surrogate reader.‡ Follow up by assessing the patient's understanding of written and verbal instructions. Additional tests, such as the Rapid Assessment of Adult Literacy in Medicine (REALM) and the short and long forms of the Test of Functional Health Literacy in Adults (S-TOFHLA and TOFHLA) have reasonable reliability and validity, but no measures of sensitivity and specificity.[59,104]
Posttraumatic stress disorder†	"Have you experienced trauma, torture, or violence in the past?" Ascertain whether the traumatic event has been persistently re-experienced in terms of thoughts, feelings, dreams, or distress at exposure to cues that resemble aspects of the event.	For a "Yes" answer, follow up with "Do you experience SPAN (Startle, Physiological Arousal, Anger, Numbness)?" (Score ≥ 5, sensitivity 88%, specificity 91% for posttraumatic stress disorder.)[105]

(*Table continues*)

Table 2
(*Continued*)

Psychosocial issue	Initial screening questions or observation	Follow-up options for a positive screen (see Table 3 for details of psychosocial screening tests)
Sexual history	"I ask these questions of all my patients. Are you or have you been sexually active?"	For a "Yes" answer, follow up with the following questions: • "Do you have sex with men, women, or both?" • "Do you have sex with more than one partner?" Or "How many partners have you had in the past year?" • "Is your sex protected?"
Somatoform disorders	Several medically unexplained physical symptoms, for ≥ two years.	Somatization disorder†: Presence of ≥ three medically unexplained physical symptoms from a list of seven, sufficient to cause the patient to take medication, see a physician, or interfere with function. Sensitivity 87–94%, specificity 94–95% in a psychiatry outpatient population for identifying somatization disorder that meets DSM-III* diagnostic criteria.[106] Multisomatoform disorder (MSD): Not yet in DSM.† Defined as the presence of ≥ three medically unexplained, currently bothersome physical symptoms from a list of 15, not due to another psychiatric disorder, and the patient has had chronic somatization for ≥ two years.[107] Fifty-three percent with MSD meet criteria for DSM-IIIR-defined somatization disorder, 35% meet criteria for abridged somatization disorder (Six to 12 instead of ≥13 unexplained physical symptoms).[108] MSD correlates with impairment in health-related quality of life, more disability days, more clinic visits, and clinician-perceived patient difficulty.[107] Presence of ≥ seven symptoms from 15-symptom list, without requirement for the symptoms being medically unexplained or for chronic somatization, has 85% sensitivity and 77% specificity for MSD.[108] Studies were done in a primary care population.

* This table and Table 3 list specific psychosocial questions, relevant to implementing TIPS, that are helpful in eliciting sensitive information (sexual history, literacy, health-related behaviors) and in pursuing diagnoses of suspected, commonly encountered psychosocial conditions.

† The specific diagnosis can be confirmed by using the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition* (DSM-IV), which provides diagnostic criteria and epidemiologic information for most recognized psychiatric disorders.[109]

‡ David H. Baker, MD, MPH, associate professor of medicine and division chief of internal medicine, Feinberg School of Medicine of Northwestern University, Chicago, IL. Personal communication, Oct. 6, 2004.

iting the educational objectives and material to be covered at each visit; negotiating with the patient; and checking for the patient's comprehension and agreement. A useful model for counseling behavioral change is based on "readiness for change" theory.[58,61,62] The task of a physician is to assess which stage (precontemplation, contemplation, determination, action, maintenance, or relapse) best describes the patient's readiness to change, and then to target the educational intervention based on the stage. For example, for a patient who is not even contemplating a change, assessing his or her understanding and concerns, promoting reflection, or just giving brief general advice is appropriate. For a patient who is ready for action, it is appropriate to discuss specific strategies. There are frequently opportunities for preceptors to role model and teach the complicated skill sets related to patient education and behavior change.

Sometimes the preceptor may encounter a resistant learner. In this situation, connecting with the learner, creating an individual-specific safe and supportive learning environment, understanding the resistance, assessing the trainee's needs, and tailoring an intervention to meet those needs become especially important. The preceptor can also apply patient education and behavior change strategies[58] and the "readiness for change model"[58,61,62] to the trainee and use them to guide and supplement the preceptor's use of TIPS. As with resistant patients, it is important that the preceptor maintain empathy for resistant learners and flexibility in teaching method. Attention to "parallel process," as discussed above, may be particularly important in interacting with resistant learners. The preceptor can help prevent trainee resistance by using TIPS selectively, within available time frames and when such an approach is clearly relevant to the problem at hand and likely to improve patient (or trainee) outcome.

Additional considerations

While the TIPS listed in Table 1 are focused on single preceptor interactions, in longitudinal precepting situations learning will build from one interaction to the next, as the preceptor's relationship with and understanding of the trainee, the trainee's trust in the preceptor, the trainee's attitudes, and the trainee's skills develop. Initially, methods may focus on raising awareness and basic communication skills, whereas, as the trainee matures, more attention may be given to differential diagnosis, clinical decision making, advanced communication skills, and reinforcement of attitudes and skills related to the psychosocial aspects of care. Over time and multiple interactions, most tools in the toolbox can be used, and the learning (or reinforcement of previous learning) can be comprehensive.

Finally, it should be acknowledged that the TIPS presented in Table 1 and demonstrated in the examples are cognitive descriptions of teaching skills. To be mastered, skills need to be learned by repeated cycles of practice, accompanied by feedback and/or reflection on performance.[63–65] By applying these teaching methods in the context of one's own precepting or in simulated situations, eliciting feedback from trainees and colleagues, reviewing audio or videotapes of

Table 3

Details of Psychosocial Screening Tests*

Screening test	Test questions and scoring method
Alcohol Use Disorders Identification Test (AUDIT)[88]	1. How often do you have a drink containing alcohol? (Never, 0 points; ≤ monthly, 1 point; 2–4 times per month, 2 points; 2–3 times per week, 3 points; 4 or more times per week, 4 points) 2. How many drinks containing alcohol do you have on a typical day when you are drinking? (1–2 drinks, 0 points); 3–4 drinks, 1 point; 5–6 drinks, 2 points; 7–9 drinks, 3 points; ≥ 10 drinks, 4 points) 3. How often do you have 6 or more drinks on 1 occasion? (Never, 0 points; < monthly, 1 point; monthly, 2 points; weekly, 3 points; daily or almost daily, 4 points) 4. How often during the last year have you found that you were not able to stop drinking once you had started? (Same as question 3.) 5. How often during the last year have you failed to do what was normally expected from you because of drinking? (Same as question 3.) 6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session? (Same as question 3.) 7. How often during the last year have you had a feeling of guilt or remorse after drinking? (Same as question 3.) 8. How often during the last year have you been unable to remember what happened the night before because you were drinking? (Same as question 3.) 9. Have you or someone else been injured as a result of your drinking? (No, 0 points; yes, but not in the past year, 2 points; yes, during the past year, 4 points) 10. Has a relative or friend, a doctor, or other health care worker been concerned about your drinking or suggested you cut down? (Same as question 9.) Score: Add all points; range 0–40.
AUDIT-C[94,95]	Questions 1–3: Score range 0–12.
AUDIT-3[94,95]	Question 3: Score range 0–4.
CAGE[88]	C = Have you ever felt you ought to *cut down* on your drinking? A = Have people *annoyed* you by criticizing your drinking? G = Have you ever felt bad or *guilty* about your drinking? E = Have you ever had a drink first thing in the morning (*eye opener*) to steady your nerves or get rid of a hangover? Scoring: 1 point for each "yes" response; add all points; range 0–4 points.
Patient Health Questionnaire (PHQ)-9[101]	Over the last 2 weeks, how often have you been bothered by any of the following problems? 1. Little interest or pleasure in doing things 2. Feeling down, depressed or hopeless 3. Trouble falling or staying asleep or sleeping too much 4. Feeling tired or having little energy 5. Poor appetite or overeating 6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down 7. Trouble concentrating on things, such as reading the newspaper or watching television 8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual. 9. Thoughts that you would be better off dead or of hurting yourself in some way Score: Answers are given on a Likert-type scale where 0 = not at all, 1 = several days, 2 = more than half the days, and 3 = nearly every day. Add all points; range 0–27.
Primary Care Evaluation for Mental Disorders (PRIME-MD) anxiety[98,109]	
For panic disorder	1. You indicated that you had an anxiety attack this month. Have you had four attacks in a 4-week period? If No: Are you afraid of having another attack? (If Yes to either, go to question 2.) 2. Does the attack sometimes come *suddenly out of the blue*? If unclear: In situations where you don't expect to be nervous or uncomfortable? (If Yes, go to question 3.) 3. Ascertain what symptoms were present the last really bad time this happened (stop when ≥4 symptoms present): Shortness of breath; heart racing, pounding, or skipping; chest pain or pressure; sweating; choking feeling; hot flushes or chills; nausea, upset stomach, or feeling of impending diarrhea; dizzy, lightheaded, unsteady, or faint feeling; tingling or numbness; trembling or shaking; things around one seemed unreal; fear of dying; fear of losing control or going crazy. Score: If answers to questions 1 and 2 are positive and ≥4 symptoms present, PRIME-MD suggests panic disorder. If 1 and 2 are positive, and <4 symptoms present, PRIME-MD suggests anxiety disorder, not otherwise specified.

(*Table continues*)

Table 3
(*Continued*)

Screening test	Test questions and scoring method
For generalized anxiety disorder	1. Have you felt nervous, anxious, or on edge *on more than half the days in the last month?* (If Yes, go to question 2.) 2. In the last month, have you *often* been bothered by: Feeling restless so that it is hard to sit still; getting tired very easily; muscle tension, aches, or soreness; trouble falling asleep or staying asleep; trouble concentrating on things, such as reading a book or watching TV; becoming easily annoyed or irritated? (Go to question 3 if answers to ≥2 questions positive.) 3. In the last month have these problems made it hard for you to do your work, take care of things at home, or get along with other people? (If Yes, go to question 4.) 4. In the last month, have you been worrying *a great deal* about *different* things? Has this been on more than half the days in the last month? (If Yes, to both, go to question 5.) 5. Have you had all of these problems, like feeling nervous, anxious, or on edge, and (symptoms identified by the patient in question 2) for as long as 6 months? Score: If ≥2 symptoms from question 2, and positive responses to questions 1, 3, 4, and 5 are present, PRIME-MD suggests generalized anxiety disorder. If some responses are positive, consider anxiety disorder, not otherwise specified. In either case, ask whether the current symptoms are probably due to the biologic effects of a physical disorder, medication, or other drug. If Yes, "rule out anxiety disorder due to physical disorder, medication or other drug" is an appropriate tentative diagnosis.
SAFE[102]	S = *Stress/Safety:* What stress do you experience in your relationships? Do you feel safe in your relationships/marriage? Are you concerned about your Safety? A = *Afraid/Abused:* People in relationships/marriages often fight; what happens when you and your partner disagree? Are there situations in your relationship where you have felt afraid? Has your partner ever threatened or abused you or your children? Have you been physically hurt or threatened by your partner? Are you in a relationship like that now? Has your partner forced you to engage in sexual intercourse that you did not want? F = *Friends/Family:* Are your friends aware that you have been hurt? Do your parents or siblings know about this abuse? Do you think you could tell them, and do you think they would be able to give you support? Has your partner prevented you from leaving the house or seeing your friends or family? (Assess the degree of social isolation.) E = *Emergency Plans:* Do you have a safe place to go, and the resources you (and your children) need in an emergency? If you are in danger now, would you like help in locating a shelter? Would you like to talk with a social worker/counselor/me to develop an emergency plan?
Somatoform disorders	*Somatization disorder 7-symptom screening list:*[106] Shortness of breath; dysmenorrhea, burning in sex organs, lump in throat, amnesia, vomiting, painful extremities. To count, symptoms must be medically unexplained and sufficient to cause the patient to take medication, see a physician, or interfere with function. *Multisomatoform disorder (MSD) 15-symptom list:*[107] During the past month have you often been bothered by: stomach pain; back pain; pain in your arms, legs, knees, hips, or joints; menstrual pain or problems; pains or problems during sexual intercourse; headaches; chest pain; dizziness; fainting spells; feeling your heart pound or race; shortness of breath; constipation, lose bowels, or diarrhea; nausea, gas, or indigestion; feeling tired or having low energy; trouble sleeping. To count, symptoms must have bothered patient a lot rather than a little. Physician has to answer "no" to this question: "Based on your clinical judgement, does the symptom have a physical explanation that is adequate to explain its severity and associated disability?" The patient has to have had somatoform symptoms for ≥2 years. The condition cannot be explained by other psychiatric illnesses (e.g., depression).
SPAN[105]	S = *Startle:* Have you been jumpy or easily startled? P = *Physical upset:* Have you been physically upset by reminders of the event? (This includes sweating, trembling, racing heart, shortness of breath, nausea, or diarrhea.) A = *Anger:* Have you been irritable or had outbursts of anger N = *Numbness:* Have you been unable to have sad or loving feelings? Score: Each item is rated 0–4 in severity (0 = not at all distressing, 1 = minimally distressing, 2 = moderately distressing, 3 = markedly distressing, 4 = extremely distressing), then item scores are added; range 0–16.
TWEAK[88]	T = *Tolerance:* How many drinks can you hold? (≥6 drinks indicates tolerance.) How many drinks does it take before you feel the first effects of alcohol? (≥3 indicates tolerance.) W = *Worried:* Have close friends or relatives worried or complained about your drinking in the past year? E = *Eye opener:* Do you sometimes take a drink in the morning when you first get up? A = *Amnesia:* Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember? K = *Kut down:* Do you sometimes feel the need to cut down on your drinking? Scoring: 2 points for tolerance; 1 point each for annoyed, cut down, or eye opener; sum all points; range 0–7 points.

* This table provides details of the follow-up screening tests recommended in Table 2, when the initial screening questions or observations listed in Table 2 suggest a specific psychosocial condition. Table 2 provides tests characteristics, including sensitivity and specificity, when available. Together Tables 2 and 3 provide a list of specific psychosocial questions, relevant to implementing TIPS, that are helpful in eliciting sensitive information and pursuing diagnoses of suspected, commonly encountered psychosocial conditions. Specific diagnoses can be confirmed by using the *Diagnostic and Statistical Manual of Mental Disorders, fourth edition* (DSM-IV), which provides diagnostic criteria and epidemiologic information for most recognized psychiatric disorders.[109]

one's performance, and taking time to reflect and learn from experiences and feedback, preceptors can develop expertise in the use of these tools. Textbooks[66–67] and faculty development resources[68–71] are also available, as are workshops at professional meetings.

Discussion

While numerous programs, workshops, and publications address general teaching skills,[72–76] and some have addressed teaching skills in specific content areas such as preventive medicine,[77] EBM,[78] communication skills, and psychosocial medicine,[68–71,79] TIPS are distinguished by focusing on the teaching and reinforcement of important content areas by generalist outpatient preceptors who may not have expertise in the content areas. Unfortunately, content that is taught in isolated medical school curricula and residency rotations may not be reinforced by medical school and hospital systems or in the subsequent clinical experience of trainees, i.e., in the "hidden" and "informal" curriculum of medical training institutions.[80,81] In fact, humanistic attitudes and behaviors have been shown to erode during medical training,[12–15] despite our ability to teach them effectively.[4–8] Hopefully, the TIPS provided in this paper, which have undergone numerous cycles of feedback and revision, are formatted in a way that will promote their adoption by generalist preceptors.

Because psychosocial TIPS involve teaching attitudes and doctor –patient interaction skills, they include educational methods that are more sophisticated than previous models for precepting such as the "one-minute preceptor."[82,83] Like the "one-minute preceptor," psychosocial TIPS includes assessing the trainee's clinical reasoning, giving feedback, providing focused teaching points, and being practical and efficient. Unlike the "one-minute preceptor," psychosocial TIPS includes methods designed to influence attitudes and teach doctor–patient skills, such as role-modeling, experiential learning, reflection on performance, and creating a safe, supportive learning environment. Psychosocial TIPS also includes teaching in the presence of the patient and recognizes the "parallel" process between preceptor–trainee and trainee–patient interactions.[53–55]

In developing these TIPS, we focused on several principles of effective adult learning:

- Being-learner centered (assessing the trainee, and tailoring teaching interventions to the trainee's needs)
- Engaging the trainee (by being practical and trainee-centered)
- Focusing and limiting the teaching to what can be accomplished within the available time
- Addressing needs in whatever domain is required– cognitive (knowledge and higher-order clinical reasoning and judgment), affective (attitudes), or psychomotor (skills, behavior)
- Using multiple methods to address different learning preferences and the need for reinforcement.[52]

While designed for outpatient preceptors, many of the TIPS are also applicable to teaching in the inpatient setting.

There are some limitations to these TIPS that should be kept in mind. While based, wherever possible, on educational research and theory, they are the product of experts' and consensus opinions. The degree to which they can be adopted and applied by generalist and specialist preceptors, and the degree to which their application influences the knowledge, attitudes, and behaviors of trainees, remains to be tested.

Just as doctor–patient interaction skills can be difficult to master for trainees and require enlightened precepting, it must be acknowledged that sophisticated teaching skills may not readily be learned by preceptors from an article or a textbook. We have tried to include here teaching methods that are a natural extension of the approach of many generalist preceptors and that can be tried and practiced on one's own. That said, learning to teach these issues will likely be fostered by attending workshops that include practice, reflection, feedback from other participants and skilled preceptors, and help with handling resistant learners and failed attempts.[68–71] Such workshops are provided by the American Academy on Physician and Patient and the Bayer Institute in the U.S. and the Medical Interview Teaching Association in the United Kingdom.[68–71] We anticipate that psychosocial TIPS will provide a cognitive structure that will be useful to participants in and facilitators for such workshops.

The TIPS presented here are confined to teaching in the context of precepting patient care. They do not address practice operations. Ideally, the preceptor's practice should articulate and communicate a mission that includes humanistic care. The receptionist and the clerical, administrative, and nursing staff can model humanistic interactions with patients. Systems can be present that provide important services for the patient, such as patient education, notification of test results, accessible appointment systems, telephone or e-mail access etc. Patients and trainees can be directed to resources related to specific psychosocial problems.[84–87] To the extent that the preceptor controls the practice operations, the preceptor can help establish a practice culture that demonstrates sensitivity to patient needs.

TIPS do not address nondyadic methods of teaching and learning, which can supplement and reinforce humanistic care. Home visits can be incorporated into the trainee's schedule when appropriate. Trainees can be given reflective writing assignments or be assigned projects that promote learning in this area. In clinic settings where there are several trainees, didactic and small-group approaches to teaching can be integrated into the total educational milieu. For example, humanistic approaches to patient care and humanistic topics can be included in pre- or postclinic conferences. Patients can be included in some teaching conferences. Representatives from different ethnic groups can be invited to conferences in order to increase awareness of the groups' needs and problems, and to draw attention to cross-cultural issues. In small-group settings, preceptors can skillfully expose nonpsychosocially to psychosocially oriented trainees, to promote exchanges of perspectives and experiences and promote humanistic attitudes.

Although precepting has some limitations, it is a very important teaching method. When skillfully implemented, it incorporates several teaching approaches: the application of knowledge to real patients and their problems, role modeling, practice, feedback, reflection, and discussion. Perhaps more than any other educational methodology used to teach humanistic care, it has the potential to influence practice patterns. While additional study is required to determine which precepting strategies are most ef-

fective in promoting humanistic approaches to care by trainees, we hope that the TIPS presented in this paper will serve as an interval model by which both generalist and specialist preceptors can teach and reinforce learning in this area.

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