The Medical Interview: A Core Curriculum for Residencies in Internal Medicine

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A core curriculum for teaching medical interviewing is presented that enhances the internist's skills in a broad range of interactions with patients. Learning these skills is now left to chance and is often deficient. Four objectives are developed: patient-centered interviewing and treatment; an integrated (biopsychosocial) approach to clinical reasoning and patient care; personal development of humanistic values; and psychosocial and psychiatric medicine. Teaching options include real and simulated encounters with patients, observation with discussion, and use of groups. A general strategy for implementing the curriculum at the local level requires the intellectual and financial support of the dean and department chairman, and a multidisciplinary faculty committed to developing, implementing, and evaluating the currriculum. At many programs, faculty development will be necessary.

A FUNDAMENTAL CHARACTERISTIC of internal medicine is the intelligent, sensitive, and systematic collection of information from patients in various settings. The medical interview is one of the most important tools in this process (1). We define the interview as the entire medium of patient-physician interaction. During the interview the internist undertakes several tasks simultaneously (2). The internist approaches the patient as a unique person with his own story to tell, promotes trust and confidence, clarifies and characterizes the patient's symptoms and concerns, generates and tests many hypotheses that may include biological and psychosocial dimensions of illness, and creates the basis for an ongoing relationship. To become competent at this process, the internist must be systematically taught and encouraged to develop his or her skills in the interview process. The model curriculum presented here is an effort by the authors and many members of the Society for Research and Education in Primary Care Internal Medicine (SREPCIM) Task Force on the Medical Interview to develop a standard for this broad-based, critically needed teaching effort; see the acknowledgments section for more detail on this effort.

There are several reasons to define a curriculum for the medical interview. First, most teachers believe that a standard for such work simply does not exist and is needed. Without this curriculum, faculty wishing to ignore the area may do so by claiming that their efforts are sufficient. Second, a model may stimulate new approaches and raise new questions for experienced teachers. The curriculum will help structure options facing persons new to this area and avoid pointless trial and error. Last, and most important, it is well documented that residents and practicing physicians lack fundamental interviewing skills (3-6).

The potential benefits of a successful interview curriculum are enormous. Patient and practitioner satisfaction depends, in part, on the quality of the interaction between them. Preliminary studies along several lines show a correlation between characteristics of the encounter and satisfaction (7-11). Second, the accuracy and completeness of the data elicited are a function of interview technique. In general, excellent interviewers spend comparable periods of time to that spent by poor interviewers, but glean significantly better information from the patient (3, 12, 13). The practitioner's spectrum of concerns expands (2, 14). When one begins to listen to patients, several things happen. Major, as opposed to initial, complaints are clarified and addressed (15). The personal style of the patient becomes clear (16), so individualized treatment may be used with enhanced comprehensiveness and compliance (17). Psychological and social complaints and maladjustments are put into proper context in the care process (18).

The overall goals of this curriculum for medical interviewing are: to teach internists to be sensitive and responsive in their interaction with patients; to promote the ability of internists to elicit, understand, integrate, and care for the biological, psychological, and social needs of their patients; and to help internists develop the knowledge, interpersonal skills, and self-awareness necessary to work effectively with a broad range of patients with diverse concerns over time. Though the curriculum was developed specifically for primary care internists, it applies to other primary care providers, subspecialists, and students.

General Objectives

The general objectives of an interviewing curriculum are shown in Table 1. The objectives are separated into four components to help clarify exactly what is required

Table 1. General Objectives of a Curriculum for the Medical Interview

Patient-centered interviewing and treatment
Integrated (biopsychosocial) approach to clinical reasoning and patient care
Personal development of humanistic values
Psychosocial and psychiatric medicine

► From the Working Group on the Model Curriculum of the Task Force on the Medical Interview and Related Skills of the Society for Research and Education in Primary Care Internal Medicine (SREPCIM).

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Table 2. Patient Centered Interview and Treatment

- Knowledge
  - Name the seven ways to characterize a symptom (19)
  - Recognize and define several forms of questions (open-ended, closed-ended, directive but nonbiased, directive and biased) (20)
  - Understand the stages of an interview and their management (opening, characterization of present illness and life setting, closing, appropriate review of systems) (20)
  - Understand that the interview has several functions (interest and commitment to patient, facilitating communication, calibrating and overcoming barriers in communication, surveying patient problems, selecting priorities and limitations, negotiating contract, use of self and helping skills, the avoidance of hindering skills) (2)
  - Understand the components of a mental status examination and how to use it in a patient-centered interview (21)
  - Name several forms of nonverbal behavior and understand what may be communicated in this way (22)
  - Define the characteristics of a helping relationship and "unconditional positive regard" (23)
  - Understand several models of the doctor-patient relationship (active and passive, guidance and cooperation, mutual participation) and explore their clinical applications (24-26)
  - Define types of patients who require different interviewing and treatment styles (16, 17)
  - Define transference and countertransference and explore how each effects medical relationships (27)
- Skills
  - Competently elicit the patient's story of illness that includes a detailed delineation of symptoms while at the same time pursuing the broader life setting in which symptoms occur
  - Express interest in and commitment to the patient
    - Verbal behaviors: introduce self, get patient's name clear, attend to physical comfort, elicit patient's view of the problem, elicit patient's request, clarify extent of commitment, discuss questions
    - Nonverbal behaviors: touch, get comfortable, contact between eyes
  - Facilitate communication
    - Verbal behaviors: allow patient to give his own story of illness, use a balance of open-ended and closed-ended techniques, use nonbiasing questions, seek clarification of vague or ambiguous data, use empathy where appropriate, echo patient's words and affects, nonjudgmental, unconditional positive regard
    - Nonverbal behaviors: arrange space comfortably, nod, show affect, posture communicates interest, echo patient's nonverbal behavior, quiet attention
  - Avoid hindering behavior
    - Verbal behavior to be avoided: use of technical language, injecting biases, false or premature reassurance, noninteraction, discussion of fees first, "there is nothing wrong—it's all in your head," frequent interruptions
    - Nonverbal behavior to be avoided: posture communicates disinterest, not listening, reading chart or writing note during interview, allowing interruption, closed posture
  - Calibrate and overcome barriers to communication (deafness, language or cultural differences, high anxiety, strong affect)
    - Check barriers and compensate: talk louder, get interpreter
    - Observe verbal and nonverbal signs of barriers at outset
    - Inquire in an open-ended way about affect
    - Openness to a "hidden agenda" (15)
    - Recognition and characterization of mental status changes when present (28)
  - Negotiation and contracting—share responsibility for patient care (26)
    - Survey patient's problems: "What else is bothering you? Anything else? . . ."
    - Select a priority and set limits: "What bothers you the most?"
    - Elicit patient's view of illness and patient's request
    - Be willing to individualize treatment plans
    - Check patient's understanding of diagnosis and treatment plan
  - Encourage patient's use of self-help skills
    - Seek and integrate patient's experience with illness into treatment plan
    - Encourage patient to take control of own care as appropriate
    - Use specific therapies (behavior modification, crisis intervention) when appropriate
    - Define the patient's strengths and use them in the treatment process
- Attitudes
  - Unconditional positive regard for patients—approach patients respectfully and nonjudgmentally
  - Respect for patient autonomy and individuality
  - Willingness to join with patients as partners—to share some of the diagnostic and treatment processes and decisions with them
  - Willingness to work with and learn from patients with diverse backgrounds and personal styles

to effectively teach medical interviewing. The notion of the interviewing process is broadened to include the joining of physician and patient in a therapeutic relationship over time that sensitively and competently attends to the patient's psychosocial and biological well being.

The first objective, patient-centered interviewing and treatment, includes the traditional medical tasks of taking the history, arriving at an explicit and complete diagnosis, and providing appropriate treatment (prescription, education, and therapy). This objective encompasses the formation of a helping relationship with the patient, encouragement of active patient participation in the diagnostic and treatment processes, and careful attention to the biological and psychosocial dimensions of the patient's illness, as well as the skilled communication of information.

A biopsychosocial (integrated) approach to clinical reasoning and patient care integrates the psychological and social dimension of illness with the biological dimensions in both the diagnostic and therapeutic processes. This objective is contrasted with a naive, reductionist, exclusively biotechnical approach sometimes used and reinforced in internal medicine.

The third objective, personal development of humanis-

tic values, recognizes that becoming a physician is a developmental process, requiring growth, adaptation, and change. The young physician constantly encounters a wide range of patients who are facing sickness, disability, and death. The resident physician often has no special skills for facing these issues personally or with patients. So it is not surprising to find that the focus of many residents is mainly biotechnical. Asking residents in such a situation to be constantly "patient centered" without focusing time and energy on their own personal development is unrealistic and unwise.

Finally, psychosocial and psychiatric medicine is included as an objective to emphasize that without knowledge and skills in this area, the physician will lack conceptual and practical tools needed to integrate the psychosocial components of illness with the biological.

In Tables 2 to 4, the first three general objectives are developed in more detailed, operational terms using the traditional educational categories of knowledge and cognitive skills, behavioral and interpersonal skills, and attitudes and self-awareness. Each category begins with basic and proceeds to more advanced objectives. Basic references are provided to serve as a starting point for further reading.

Table 5 includes a basic set of topics in psychosocial and psychiatric medicine that must be integrated into an interviewing curriculum for the interviewer to have the understanding needed to use the data elicited. Although major areas critical to a curriculum in medical interviewing are touched upon, no claim is made for an exhaustive model.

Each individual teaching exercise may focus on knowledge, skills, and attitudes from several different objectives simultaneously. For example, a workshop on problem patients may focus on knowledge based in psychosocial medicine about recognition and definition of types of problems or "hateful" patients, skills from patient-centered interviewing on how to set limits, and attitudes from personal development to learn about the personal origins of the strong reaction elicited by these patients. It would be arbitrary and unnatural to have a teaching exercise that focused exclusively on a single objective, because there is considerable overlap. When specific objectives for an exercise can be defined in advance in operational terms, it clarifies purpose for both educators and students and serves as a guide to evaluation. Objectives should be specific and clear enough to communicate the expected outcomes of the exercise but not so rigid or detailed that creativity and active learner participation are limited. Most, if not all, areas defined under the four objectives can be covered over the 3 years of the residency program. Tables 2 to 5 may be used as a general outline to define strengths as well as weaknesses in current curricula.

Teaching Strategy

The teaching activities chosen at any individual site will depend on the interests, skills, and time available for the faculty, and also on the specific objectives of the program. Specific knowledge, skills, and attitudes from the larger overall curriculum should be operationally defined for each exercise, and an effort should be made to cover the depth and breadth of the curriculum through a series of integrated progressive steps over the 3 years of the residency program. In general, the actual behavioral skills of interviewing are best taught intensively in a series of supervised encounters with patients (both real and simulated), whereas the attitudinal and personal development objectives are more effectively taught in a well defined small group meeting over time that discusses patient care issues and the personal struggle of becoming a physician. Grand rounds and lectures may be effective ways of transmitting knowledge and demonstrating attitudes, but their effect on behavioral skills is more limited. The interpersonal skills and self awareness needed in interviewing are most effectively taught when the supervisor and resident share a series of encounters over time to build mutual trust, respect, and a common language, rather than in isolated teaching exercises.

Teaching Options

The teaching options (Table 6) described below can be adapted to each level of resident interviewing skill. This list reflects major approaches that teachers have found useful, but is not exhaustive. Objectives relevant to each type of exercise are given, together with a description of the major teaching options.

The first class of teaching options is supervised encounters with real patients. *Brief encounters* with real patients focus on greeting the patient, initiating the interview, nonverbal observation, and setting limits. This method is made effective by going from bed to bed in a ward without significant prior selection of patients. This is an efficient and stimulating exercise. *Problem-centered visits* (nonacute emergency, ward, or office) begin with initiating skills as in brief encounters but expand to include symptom development and characterization, hypothesis generation and testing in a time-limited setting, negotiation, development of the relationship, characterization of the patient as a person, and need for well defined closure. These visits can be done with selected patients on the ward or in most outpatient settings; they provide greater reality, but they take longer and induce passivity in both teacher and student unless the objectives are kept clearly in focus. The *extended interview and examination* (the "complete physical") can focus on any of the skills, attitudes, or knowledge shown in Table 2 but works best when a few well defined areas are selected for focus. These sessions are costly in terms of faculty time.

The advantage of using real patients is that the exercise is realistic, the clinical relevance is seen as genuine, and the full complexity of clinical issues is available. A disadvantage is the difficulty in controlling the material; a dramatic or pressing aspect of the case may overwhelm the focus on routine basic matters which may be more important in the long run. Although students may question the ethics of using sick patients, patients usually enjoy the opportunity to educate, the attention, and the relief from boredom. The use of the extended interview and examination is most effective once a working relationship between student and instructor is established. At that point

Table 3. Biopsychosocial Approach to Clinical Reasoning and Patient Care

Knowledge
Know the multiple dimensions of illness when viewed from a systems model (from microcellular → organ → person → family → culture) (14)
Know the advantages and disadvantages of a purely biotechnical approach to patients (29)
Consider the psychosocial setting of illness onset as a variable in all patients—important for both diagnosis and care (28, 30, 31)
Define and differentiate conversion, hypochondriasis, malingering and somatization disorder (28, 32-35)
Be aware of several well established mind-body connections (placebos, psychoneuroimmunology) (36-38)
Recognize and define decision-making modes used in clinical reasoning (39, 40)
Recognize and define the sequence of cognitive processes involved in diagnostic reasoning (symptom analysis → problem identification → hypothesis generation → hypothesis analysis → hypothesis assembly) (41)
Define and explore the illness when viewed as a behavior (42)
Skills
Explore, through interview and physical examination, biological, psychological, and social dimensions of illness
Consider the influence of familial, social, and psychological factors when assessing the patient's illness and when formulating treatment plans
Explore the life setting of illness onset when eliciting a history of present illness
Evaluate mental status in the setting of a sensitive patient-centered interview
Consider broadly-based differential diagnoses when testing hypotheses using both biological and psychosocial variables
Learn to tolerate ambiguity and the necessity of having to make decisions based at times on incomplete or conflicting data
Identify the decision-making mode (40) and dissect the hypothesis-generating process with selected patients (41)
Attitudes
Curiousity about and attention to the biological, psychological, social, and spiritual dimensions of illness that may occur simultaneously

work can be done on the specific forms of questioning, showing the physical examination as an intelligent and integrated extension of the information learned from the interview, enhancing skills in the organization and analysis of data, relating the interview to diagnostic and therapeutic strategies, and focusing on patient education and meaningful closure.

Supervised encounters with *simulated* patients have the virtue of making it possible to standardize the content of the interview to which the student is exposed. This encounter allows more focused attention on one or another aspect of the objectives. Simulated patients (60) can be actors, volunteers, students, or patients who are real patients but have been trained to participate in student or resident education. Typically, the resident is aware that the patient is simulated, and performs a specific type of interview; the simulated patient then provides direct feedback about behavior style, affect, and information quality. Although the use of simulated patients permits control of the information obtained in the interview, it lacks verisimilitude. The events of the interview are sometimes experienced by the resident as an artifact rather than as a function of interview technique. The effort of training simulated patients is considerable.

Role-playing requires that one student take the role of the patient while another is the interviewer. The specific objectives of the exercise determine the instructions given to the participants. Such exercises facilitate experiencing empathy with the patient and allow a safe environment for experimentation with new interviewing techniques. Feedback is immediate, direct, and by peers who are highly credible. Thus, it is efficient and effective.

Role modeling implies that someone with expertise shows skills or attitudes for use with patients. The expectation is that the learners will imitate the desired behavior. This idea assumes both that the role model shows desirable behavior and that students imitate the appropriate portions of what is modeled.

Observation and discussion are methods used with either simulated or real patient encounters. The material under observation can be provided by videotape, audiotape, one-way mirrors, or by observers sitting in the room with the participants. The videotape or audiotape may have been made previously or during the teaching exercise. *Process recall* (61) is a technique in which a taped encounter is reviewed and stopped at will by the interviewer, patient, or the observer to focus on verbal or nonverbal behaviors, cognitive skills, or affective material.

Table 4. Personal Development of Humanistic Attitudes

Knowledge
Define characteristics of a helping relationship (23) and of treating patients respectfully (43)
Awareness of the need for patient autonomy in the choice-making process in medicine (26)
Awareness of the magnitude and impact of stress on resident and attending physicians (44)
Recognition of strengths and weaknesses in clinical work with patients
Awareness of one's own personal response to stress
Awareness of the nature of suffering and medicine's goals (45)
Define transference and countertransference and give examples from everyday clinical work of strong feelings elicited (27)
Explore the elements and strategies for implementing truthful disclosure and informed consent (46)
Skills
Exploration of one's personal reactions to patients
Early recognition of strong positive and negative reactions to patients
Exploration of one's own impact on patients
Early recognition of one's own signs and symptoms of distress, and exploration of methods to limit stress
Allow active patient participation in the treatment process
Attitudes
An openness and curiosity about one's own attitudes, beliefs and expectations that constitute assets and limitations, value judgments, and feelings in working with patients

Process recall is a powerful reinforcing technique because feedback for the interviewer is immediate and the data on which the feedback is based are seen clearly. *Outcome recall* focuses on the interviewer's report of information gathered in the interview as well as his cognitive and affective responses to the patient. The report may be in the form of chart review or an oral report, and allows focus on the adequacy of historical information, problem identification, the inclusion of biological and psychosocial factors in hypothesis testing, problem definition, or other designated outcomes. Although this is the commonest method of reviewing patient encounters, it is limited by the interviewer's perceptions and recall.

Group meetings are especially important in working on skills and attitudes in an efficient fashion over time. *Case conferences* can be used to discuss many parts of the curriculum but are most effective when focused on the resident's own clinical experience. These are conferences where a case is presented, in any form, and discussed. Longitudinal case conferences and group meetings have been implemented in various ways. The common thread is that a small group of people agree to meet on a regular basis over time, usually with someone with psychological expertise serving as a guide. The structure and focus of the session is determined either by the leadership or by the group. In the group structure described by Balint (62), physicians share difficult patient-related problems. The authors use a continuing case conference where real patients are seen in the group, the group determines the agenda, and one focus is on group processes of the members themselves (23). Groups may be task-oriented with specific skills developed over time. Ongoing groups provide a medium in which considerable personal growth can occur due to the development of trust, effective working relationships, and peer support and peer pressure.

Workshops involve a more extended and intensive commitment by participants of several hours to several days, with an explicit agenda and the focused opportunity for motivation and work. Knowledge that is focused and operationally defined, skill, and attitude objectives can be developed in advance, making workshops a very useful way to hurdle specific learning barriers. Topics such as physician health, stress management, problem patients, negotiating and contracting skills, or even the whole topic of interviewing have been successfully presented in workshop format.

Grand rounds are an appropriate setting in which to present specific topics focusing on transmission of knowledge. Grand rounds presentations influence attitudes through the recognition that this is an accepted part of the residency program worthy to present in this format. However, grand rounds are unlikely to have measurable influence on skills.

Evaluation

Adequate evaluation is useful to a new curriculum to insure continued development and definition. It is beyond the scope of this paper to review the literature on evaluating interview teaching, except to make several points to guide those implementing the curriculum. First, the level of preexisting skill and knowledge that residents have differs considerably, so a pre/post-test model of evaluation may be necessary to show meaningful differences. Second, explicitly differentiated objectives are more likely to permit meaningful evaluation than vague general ones. The different evaluative techniques required for knowledge, skills, and attitudes have been well reviewed (63, 64).

Table 5. Psychosocial and Psychiatric Medicine

- Acute psychiatric emergencies common in medical patients (organic brain syndrome, acute psychosis, suicidal states) (28, 47, 48)
- Dementia versus delirium versus functional psychosis (28, 47, 48)
- DSM III
  - Differentiation of affective disorders, psychoses, anxiety disorders, and character disorders (49)
  - Awareness of the five dimensions used to characterize diagnoses more fully (50)
- Identification and treatment of anxiety states and depression in primary care (include use of psychotropics and when to refer) (28, 43, 48)
- Personality disorders seen commonly in medical patients (28) somaticizing patients (51), borderline personality (52), "hateful" patients (53), Munchausens (28, 54)
- Death, dying, and grieving (55, 56)
- Chronic pain versus acute pain (57)
- Drug abuse, including alcohol (43)
- Awareness of psychological manifestations associated with various medical conditions (Wilson's disease, Cushing's disease, medications) (28, 58)
- Awareness of specific treatments (crisis intervention, family therapy, biofeedback, behavior modification, stress management) (59)

Discussion

To translate the teaching objectives into a meaningful program, several important features of teaching and learning psychosocial skills must be recognized. First, residents entering a program are heterogeneous in terms of previous interview training, styles of interacting, and openness to learning in this area. To meet the objectives, teaching efforts must be directed as much as possible to the specific needs, style, and potential of each trainee. Second, learning in this area is a developmental process: it occurs sequentially and takes time. Learning requires various experiences over the 3 years of residency with a major emphasis on ongoing observation of the resident's interaction with her own patients. Third, continuity enhances learning, including both long-term relationships with patients for whom the resident serves as the primary physician, and long-term relationships with supervisors who can positively influence the developmental process of learning how to interact as a physician with patients.

Teaching and learning how to interview are best accomplished when several different methods are used over time. Because the subject matter crosses several disciplines, it is helpful to recruit faculty from other areas such as psychiatry, behavioral sciences, social work, anthropology, or epidemiology who are interested, enthusiastic, and have special areas of expertise. There is no substitute, however, for the presence of respected practic-

Table 6. Teaching Options

Supervised encounters with real patients
Brief encounters
Problem-centered visits
Extended interview and examination
Supervised encounters with simulated patients
Simulated or programmed patients
Role-playing
Role modeling
Observation and discussion
Direct observation of videotape, audiotape, or real patient encounters
Process recall
Outcome recall
Group meetings
Case conferences
Longitudinal group meetings
Workshops
Grand rounds

ing internists (65) who can integrate the biological, psychological, and social dimensions of illness, and serve as role models, as well as show how this material is helpful to patients and physicians in actual encounters in clinical internal medicine. A multidisciplinary team of internists trained in interviewing and specialists from other disciplines with a common commitment to teaching and learning about the patient interview is a desirable combination.

FEASIBILITY AND TIMING

The presentation of an effective curriculum on interviewing and related psychosocial skills is feasible in current primary care and other medical residency programs. The didactic, knowledge-oriented aspects of the curriculum can be presented in a house staff luncheon lecture series or at the beginning or end of clinic sessions. Skills-oriented portions of the program can be presented during clinic teaching hours but are more likely to be learned if presented intensively during a focused elective. Many programs use the elective or full-time clinic month commonly found in the first year to provide half- or full-time focus on such skills. The resident or intern has sufficient time and energy to concentrate on these core skills and is able to achieve sufficient mastery that subsequent episodic teaching can be used with maximum benefit. Group meetings and case conferences are used by many programs for differing portions of the 3 years and should be used at least in the last 2 years. These again are timed in relation to the residents' clinic, at noon hour teaching times, or at the end of the day. Workshop sessions are most often held on weekends and sometimes have to be done twice to allow cross-coverage. The total time will differ, but half a day per week for 1 month, 100 hours of group session, and approximately 10 to 20 hours of classroom teaching would permit a solid program to be developed. Over 3 years, this time is readily available in existing medical residency programs.

FACULTY DEVELOPMENT

Faculty development is essential in most institutions attempting such programmatic innovation and requires the support of the chairman or dean. Ideal preparation includes medical background supplemented by a fellowship that focuses on psychosocial aspects of medicine. Short of this, specific courses have become available through SREPCIM on the teaching of medical interviewing, such as the successful course held at Brown University, June 1983 (66, 67). Introductory sessions are available through the national and regional meetings of the major primary care groups (SREPCIM, the Society for Teachers of Family Medicine). The content of faculty development work should include the personal interviewing skills of the teacher, the content and teaching of an integrated approach to care, psychosocial and psychiatric medicine, and methods of teaching patient interviewing. Such work may be needed regardless of the disciplinary background of the teachers; it cannot be assumed that behavioral science or psychiatric background is preparation to teach residents how to interview. A longitudinal relationship is often forged with the clinical supervisor, and support and training of these people is critical. These teachers should be encouraged to see the resident actually interview patients.

The likelihood of the successful implementation of a curriculum in medical interviewing depends finally on institutional support, specifically on the intellectual and financial support of the dean and chairman of the department of medicine. If such support exists, a program director may be selected and faculty recruited along multidisciplinary lines. Additional resources needed include space, patient availability, audio and video taping capability, and a core library (68). Faculty must be compensated financially for their teaching efforts, and these efforts should be valued by promotion committees. It is hoped that the faculty will collaborate in adapting this overall curricular model to the particular needs and talents available for an individual program, and in doing research about the processes of interacting with patients and methods of teaching interviewing. Such dynamic groups will insure the success of the curriculum, and eventually influence the mainstream of internal medicine to appreciate the importance of the interview to all internal medicine encounters and insure that future internal medicine trainees leave residency with the necessary skills to be effective interviewers.

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A Philosophy of Medicine

. . . The moral responsibility of the physician in our society is to use all available resources for the succor of the sick and for the preservation of life, whatever the cost and the consequences. But the duty of the practicing physician toward his individual patient is only one aspect of medicine. Another aspect is made up of knowledge, practices, and points of view which bear on the welfare of the community as a whole, and on the future of mankind. And this has a large bearing, even though ill-defined because never discussed, on the formulation of a social philosophy of medicine.

In my opinion, it is meaningless and dangerous to encourage the illusion that health is a birthright of man, and that freedom from disease can be achieved by the use of drugs and by other medical procedures. Like political freedom, freedom from disease should not be regarded as a commodity to be distributed by science or government. It cannot be obtained passively from a physician or at the corner drugstore. Goethe's words apply here: "What you have inherited from your father, you must earn again or it will not be yours." Health can be earned only by a disciplined way of life.

It must be realized also that health and disease are concepts too complex and too subtle to be defined merely in gross physical terms. The meaning of these concepts is conditioned by the demands of the social environment and even more by the goals that the individual formulates for himself. Optimum performance imposes different health requirements on the plowman, the jet pilot, the philosopher. Thanks to medical science, we are in the fortunate situation of having today more than ever before the means and the knowledge to achieve the kind of health that we want, but this does not relieve us of responsibility. The truth is that the power at our disposal will be of no avail unless we work for the kind of health that we want, and this effort can be effective only if we define our individual and social goals and have the courage to make choices.

We must reconsider the wisdom of using individual longevity as the dominant criterion of social and medical ethics. We must be prepared to recognize that an excessive concern with security, with comfort, and with avoidance of pain and of effort has dangerous economic and biological implications—that such concern may, in fact, amount to social and racial suicide. I realize that any attempt to deal with these problems will involve painful conflicts with personal interests and with religious and moral convictions. Yet we have to formulate the problems in a forthright manner if we are to find their solutions.

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