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## The contextual interview: a cross-cutting patient-interviewing approach for social context

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### ABSTRACT

Patient interviewing pedagogy in medical education has not evolved to comprehensively capture the biopsychosocial model of healthcare delivery. While gathering a patient's social history targets important aspects of social context it does not adequately capture and account for the real-time reassessment required to understand evolving factors that influence exposure to drivers of health inequities, social determinants of health, and access to supports that promote health. The authors offer a patient interviewing approach called the *Contextual Interview (CI)* that specifically targets dynamic and ever-changing social context information. To substantiate the use of the CI in medical education, the authors conducted a qualitative review of the Accreditation Council for Graduate Medical Education Milestones for primary care specialties (Family Medicine, Internal Medicine, and Pediatrics). Milestones were coded to the extent to which they reflected the learner's need to acknowledge, assess, synthesize and/or apply patient contextual data in real-time patient encounters. Approximately 1 in 5 milestones met the context-related and patient-facing criteria. This milestone review further highlights the need for more intentional training in eliciting meaningful social context data during patient interviewing. The CI as a cross-cutting, practical, time-conscious, and semi-structured patient interviewing approach that deliberately elicits information to improve the clinician's sense and understanding of a patient's social context. The authors reviewed future directions in research-ing adapted versions of the CI for undergraduate and graduate medical education.

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The health of human beings is inextricably intertwined with their life context [1]. This reality is reflected in the structural inequities that lead to social determinants of health (SDoH) and drive the prevalence of chronic disease in the United States [2]. Roughly sixty percent of Americans have a chronic disease. Specific key risk factors, including chronic stress, tobacco use, inequitable access to food and nutrition, physical inactivity, and heavy alcohol use are often associated with chronic disease [3]. Health behaviors directly connect to the unique social context of the patient. Chronic disease prevalence is associated with complex, interrelated factors and circumstances such as health inequities, structural oppression, mental health, mental health treatment access, poverty, financial stress and inequitable wages, environmental stressors, and access to social support and connection [4]. A myriad of chronic diseases are also correlated with experiences of childhood trauma, including diabetes, cardiovascular disease, malignancy, lung disease, and many more [5]. The rise of deaths of despair, which

include mortality resulting from suicide, drug overdose, and alcohol-related liver disease [6,7], further illustrates the complexity of social context and its relation to morbidity and mortality. It is time to re-evaluate traditional approaches to patient interviewing within medical education and ensure that clinician-patient communication and interviewing skills have an explicit emphasis on evaluating and incorporating social context.

While George Engel's biopsychosocial model [8] is a widely adopted framework for conceptualizing health, its explicit connections to clinician-patient communication and interviewing skills in a real-time medical encounter are less clear and cohesive across medical education curricula. The act of retrospectively analyzing and appreciating the complex factors affecting patients' health outcomes outside of a clinical visit, while important, is a separate skill set than the granular communication skills and emotional intelligence required to elicit, respond to, and integrate this information in real time during a clinical visit. We believe that current training

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models for patient interviewing do not adequately develop these skills.

Gathering information about a patient's social context is a dynamic, continuous process; it is not about checking boxes or completing a one-time social history. The standard method of patient interviewing that addresses the social context has historically been described as *gathering a patient's social history*. The term *social history* is limited and does not prompt a clinician to think about the dynamic factors that *currently* and *meaningfully* influence a patient's interaction with the healthcare system and their own health. Behforouz, Drain, and Rhatigan [9] highlight the need for medical training to reconceptualize the social history portion of the clinical interview and offer an expanded and more meaningful review of complex factors that comprise *social context* [9]. Examples of their expanded social history include emotional health, perception of healthcare, access to and utilization of healthcare, and life circumstances.

Our paper complements the insights of Behforouz et al. and provides a rationale and initial educational framework for teaching an advanced model of patient interviewing during medical training: the Contextual Interview (CI) [10]. The CI is a cross-cutting, practical, time-conscious, and semi-structured patient interviewing approach that deliberately elicits information to improve the clinician's sense and understanding of the patient's unique social context [10]. We summarize the history of extant patient interviewing models and their limitations, report results of an analysis of the Accreditation Council for Graduate Medical Education (ACGME) Milestones related to patient context, and introduce the core elements of the CI.

### **Current educational models for patient interviewing**

Patient interviewing is a multidimensional activity and serves as the primary mode of ongoing cognitive and affective understanding between clinician and patient. Empirically, patient interviewing is the intentional use of specific questions directed at the patient for the collection and interpretation of pertinent health information. It can be thought of as instrumental dialogue that leads to differentials, diagnosis, and treatment planning. Patient interviewing is much more than the act of eliciting and recording data; effective patient interviewing is inherently therapeutic. It is often the connective tissue of the patient-clinician therapeutic relationship. In parallel with the sanative benefits of touch during a physical exam, patient interviewing communicates empathy, compassion, care, and respect. The patient feels attended to and connected with the clinician. Interviewing promotes engagement in recommended treatments

by creating conditions for shared decision-making and talking through ambivalence.

One misconception is that patient interviewing and other patient-clinician communication skills are only developed over many years of clinical practice and, consequently, cannot be easily taught to clinicians-in-training [11,12]. Effective patient interviewing is not solely the purview of seasoned clinicians. This misconception serves as a barrier for adopting and disseminating more advanced interviewing techniques in undergraduate and graduate medical education. It also suggests that the science of patient interviewing education is underdeveloped and demands more investigation. Another misconception is that interviewing serves as a prelude to 'real' medicine, a forerunner for evidence-based treatments and procedures. However, the growing science behind empathy, compassion, and social connection suggest that interviewing is not an overture to medicine [13]. Interviewing is medicine.

The general adoption of advanced patient-interviewing techniques appears to be stagnant. Broadly speaking, there is little indication that medical providers are interviewing differently today than they did decades ago. Current variations of patient interviewing in practice likely stem from exposure to a combination of frameworks: medical interviewing; history of present illness (HPI); general patient-clinician communication; and behavioral medicine techniques [14]. Table 1 provides a comparison of patient interviewing techniques across the medical education literature.

While these patient interviewing frameworks can be useful in certain circumstances and with certain patient issues, they lack a practical approach to patient interviewing. What is needed is a framework that is *cross-cutting*, in that the core interviewing and communication skills are applicable to a variety of patient concerns and symptoms. The learner does not have to select the right acronym for each symptom or clinical situation. The CI allows clinicians to gather meaningful patient data to understand patient circumstances, perspectives, choices, and behaviors, and to develop individualized follow-up and treatment plans anchored in their unique context.

### **ACGME milestones, social context, & support for the contextual interview**

To further strengthen the justification for training physicians in the Contextual Interview (CI), a thorough review of the ACGME milestones was conducted to determine how many milestones reference an ability to assess and understand a patient's immediate life context. The ACGME milestones represent a competency-based approach to medical education, centered on an individual learner's

**Table 1.** Summary and evaluation of patient interviewing approaches.

Summary	Strengths	Limitations
A conventional method of structuring the complex task of collecting patient information and arriving at a diagnosis or disease exclusion.	<b>Medical Interviewing [15–18]</b> Includes inherent flexibility to combine both disease- and illness-focused questions with a physical examination, differential diagnosis, and treatment planning.	Limited instruction for eliciting patient background information and social context. Little evidence that method has advanced over the past few decades.
A chronological organization of illness development from the first sign, or previous encounter, to the present.	<b>History of Present Illness</b> Follows the patient's chief complaint and informs diagnosis and treatment planning. Clinicians can follow specific, payer-designed criteria for reimbursement.	Relies on multiple close-ended questions. To make the HPI interview patient-centered, clinicians must combine it with other communication techniques.
A suite of general and situation-specific communication techniques (e.g., open-ended questions, agenda setting, shared decision-making, teach back).	<b>Patient-Clinician Communication [12,19,20]</b> Moderate evidence base suggests communication training improves patient satisfaction and empowerment, lowers patients' distress, and improves clinical outcomes.	There are many communication techniques and only some are focused on patient interviewing. Competency requires access to expert trainers, time, and funding.
Clinical models and techniques designed for motivation enhancement, brief mental health or substance use screening, or behavior modification.	<b>Behavioral Medicine Techniques [21–27]</b> Strong evidence base suggests Motivational Interviewing and SBIRT are effective in supporting behavior change. Other techniques have varied evidence (e.g., FRAMES, 5As, BATHE).	There are many behavioral medicine techniques and only some are focused on patient interviewing. Competency requires access to expert trainers, time, and funding.
A clinical framework for gathering pertinent and contextual biopsychosocial patient information.	<b>Contextual Interview [10]</b> Cross-cutting, broadly applicable. Collects real-time, biopsychosocial patient information in a responsive, time-conscious, and semi-structured way. Allows for integration of contextual data into treatment plans and improved patient-centered care.	There are no experimental studies and no published training programs.

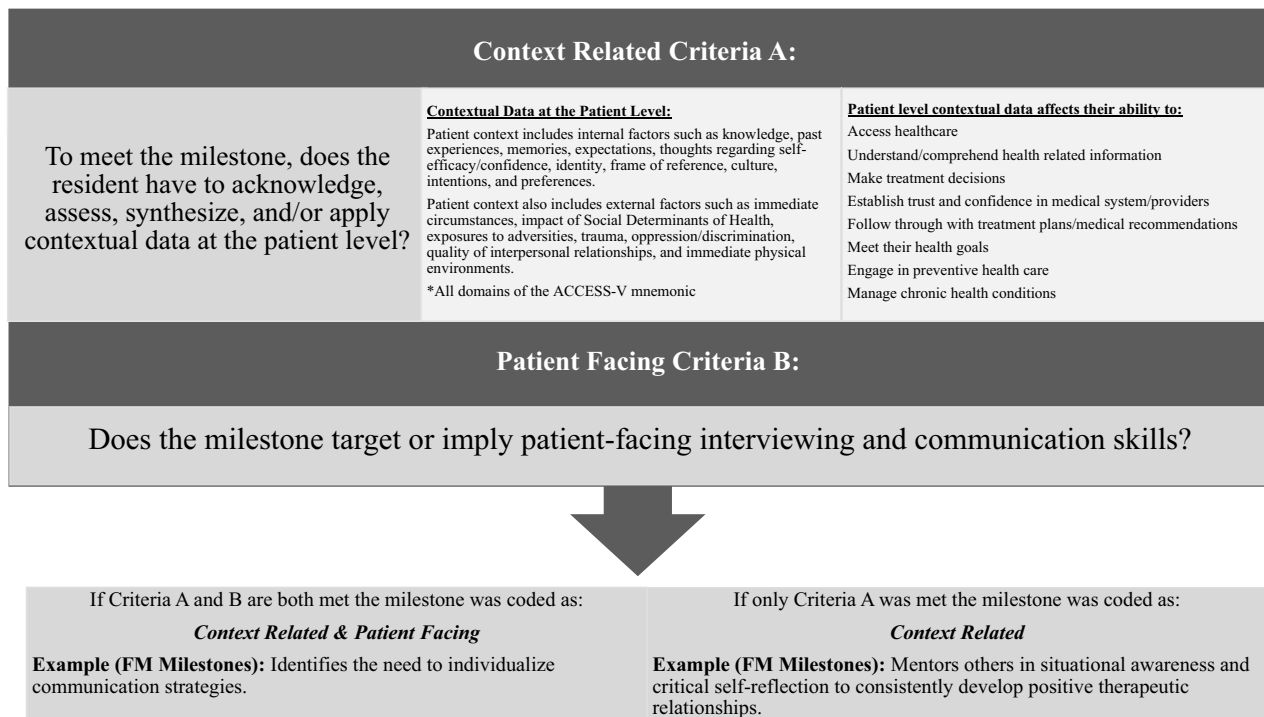
progression through key milestones across several competencies to incrementally assess acquisition of the requisite knowledge, skills, and attitudes needed to independently practice medicine. The ACGME Milestones were developed by a national consensus on specialty-specific competencies that all physicians are expected to reach before graduating residency. The milestones inherently both reflect and guide education and training across both undergraduate and graduate medical education. Two of the authors (AC, MM) separately and then together reviewed milestones, based on a checklist developed by the authors, to determine the extent to which the milestones and competencies directly relate to a patient's *context*. They reviewed the specialty-specific milestones of the primary care specialties (all of which included milestones applicable to inpatient and outpatient settings) including Family Medicine, Internal Medicine, and Pediatrics. Both reviewers met together, after independently reviewing each milestone, to discuss and resolve discordances in reviews.

Milestones were coded as *Context Related & Patient Facing*, *Context Related*, or neither. Figure 1 provides a detailed description of the checklist utilized to evaluate each milestone, along with examples. Each milestone was evaluated on whether it related directly to a patient's context (Criteria A: Context Related), such that the resident physician needs to acknowledge, assess, synthesize and/or apply patient context data to fulfill the competency. Patients' contextual data includes internal and external factors. Internal factors can include patients' knowledge, past experiences, memories, expectations, thoughts regarding self-

efficacy/confidence, identity, frame of reference, culture, intentions, and preferences. External factors can include patients' immediate circumstances, SDoH, exposure to adversities, active trauma or abuse, oppression/discrimination, racism, quality of interpersonal relationships, and immediate physical environments. These contextual factors directly impact healthcare delivery and the patient experience. For example, a patient with a physical disability and housing insecurity is likely to experience unique facilitators and barriers in their ability to access healthcare, understand and comprehend health-related information, make treatment decisions, establish trust and confidence in the medical system, follow through with treatment plans and recommendations, meet their health goals, engage in preventative health care, and manage their chronic health conditions.

If the milestone met Criteria A (Context Related), it was then evaluated on whether it targets or implies patient-facing interviewing and communications skills (Criteria B: Patient Facing). This allows differentiating between the ability to appreciate and acknowledge social context *conceptually* versus developing the interviewing and communication skills to *actively gather, synthesize, and apply* social context data and to utilize it meaningfully to positively impact a patient's healthcare trajectory and their subjective experience of the healthcare encounter.

Table 2 provides an overview of milestone data across all primary care specialties (i.e., Family Medicine, Internal Medicine, and Pediatrics) and reveals a cross discipline average of 20% of milestones meeting both Criteria A and B and coded



**Figure 1.** Coding rubric to determine if a milestone is a *context related & patient facing* or *context related* milestone.

as *Context Related & Patient Facing* (FM: 21%, IM: 23%, Peds: 17%), with an additional 13% (FM), 20% (IM), and 14% (Peds) of milestones meeting Criteria A only and coded as *Context Related*. As expected, the Patient Care and Interpersonal and Communication Skills competencies had the highest concentrations of *Context Related & Patient Facing* and *Context Related* milestones. The ability to gather, synthesize, and apply contextual data in real-time communication while interviewing a patient comprised a significant proportion of the milestones within these two competencies in each specialty (Family Medicine, [Figure 2](#); Internal Medicine, [Figure 3](#); Pediatrics, [Figure 4](#)). These results suggest that current training expectations in graduate medical education align with the purpose of the CI.

### Overview of the contextual interview

Our review of the ACGME Family Medicine, Internal Medicine, and Pediatrics milestones substantiates the critical emphasis on acknowledging, assessing,

**Table 2.** Overall percentage of *context related & patient facing* and *context related* milestones per discipline.

Primary Care Specialty	Total # Milestones	Context Related & Patient Facing Milestones	Context Related Milestones
Family Medicine	219	47 (21%)	29 (13%)
Internal Medicine	186	43 (23%)	38 (20%)
Pediatrics	150	26 (17%)	21 (14%)

synthesizing, and/or applying contextual data to improve healthcare delivery. The CI framework can assist in the delivery of patient-centered care that sensitively and adequately ensures that SDoH and key aspects of a person's life, context, and adversities are centered in their healthcare. The CI, which includes the Love, Work, Play, & Health Behaviors (LWPHb) mnemonic, was first introduced as an interviewing approach grounded in principles of Acceptance and Commitment Therapy (ACT) for primary care and behavioral health clinicians in primary care [10]. The authors refer to this approach as giving the clinician a 'snapshot' of the patient's life in key life domains, and it provides a framework for gathering pertinent and contextual biopsychosocial information [10]. Understanding a person's life and social context is a foundational concept in longstanding theories and approaches to human behavior including Functional Contextualism [28], Relational Frame Theory [29], and Acceptance and Commitment Therapy [30].

A core principle of Functional Contextualism is that human behavior can only be understood in relation to the context in which the behavior occurs [28]. Connecting this to health behavior routinely seen in primary care, clinicians addressing smoking cessation cannot adequately help these patients without understanding the context in which their smoking occurs. For example, consider a patient recently divorced from a spouse who was verbally and physically abusive for nearly a decade. This patient schedules a primary care visit for a physical and to be linked with behavioral health counseling. Imagine if this clinician were to skip the step of gathering social context data and instead



### Family Medicine: Patient Communication Related Sub-Competencies

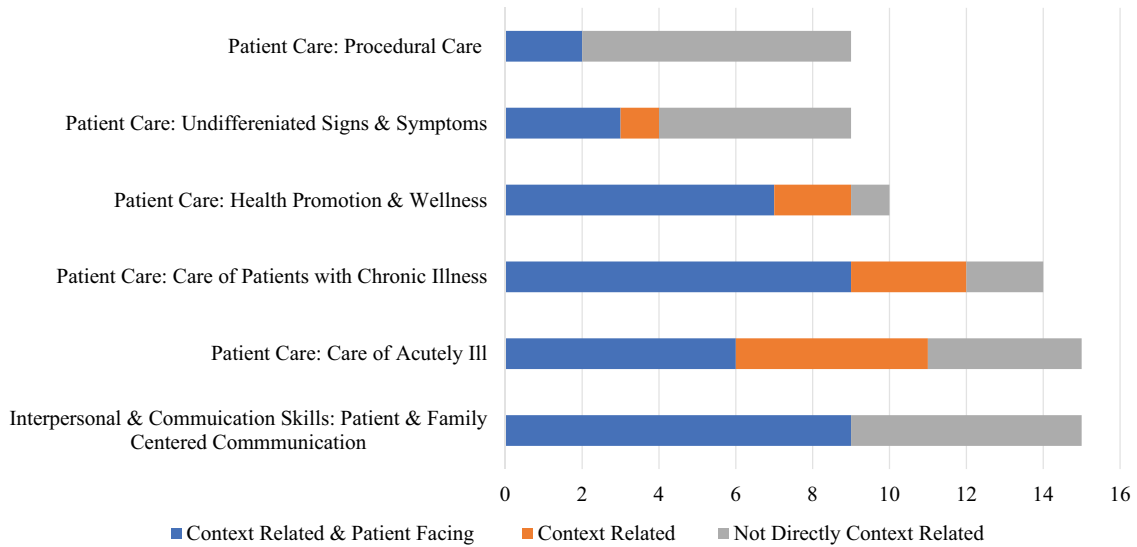


Figure 2. Number of context-related & patient-facing milestones specific to patient communication sub-competencies: family medicine.

### Internal Medicine: Patient Communication Related Sub-Competencies

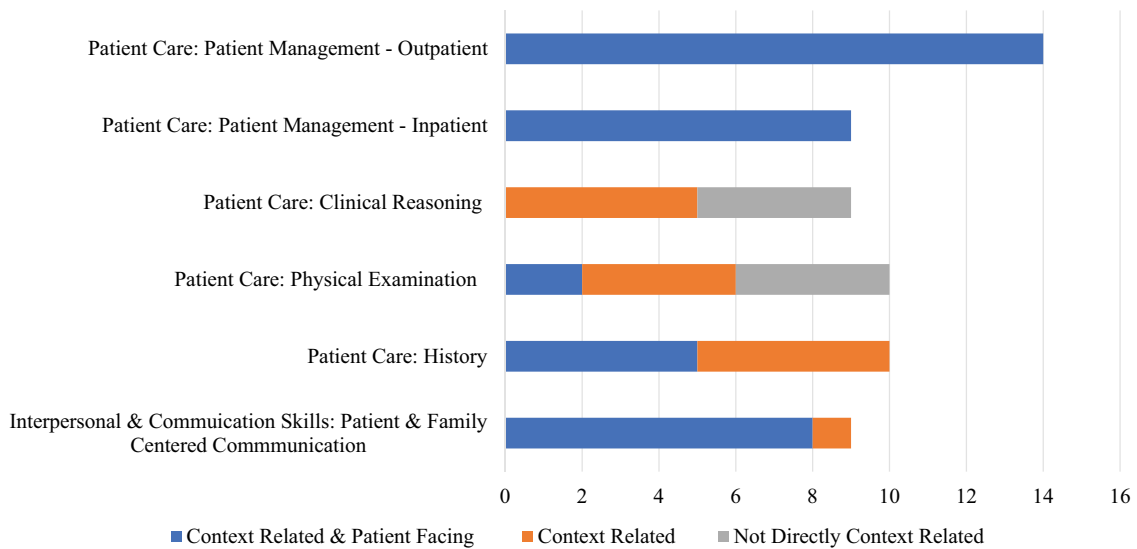
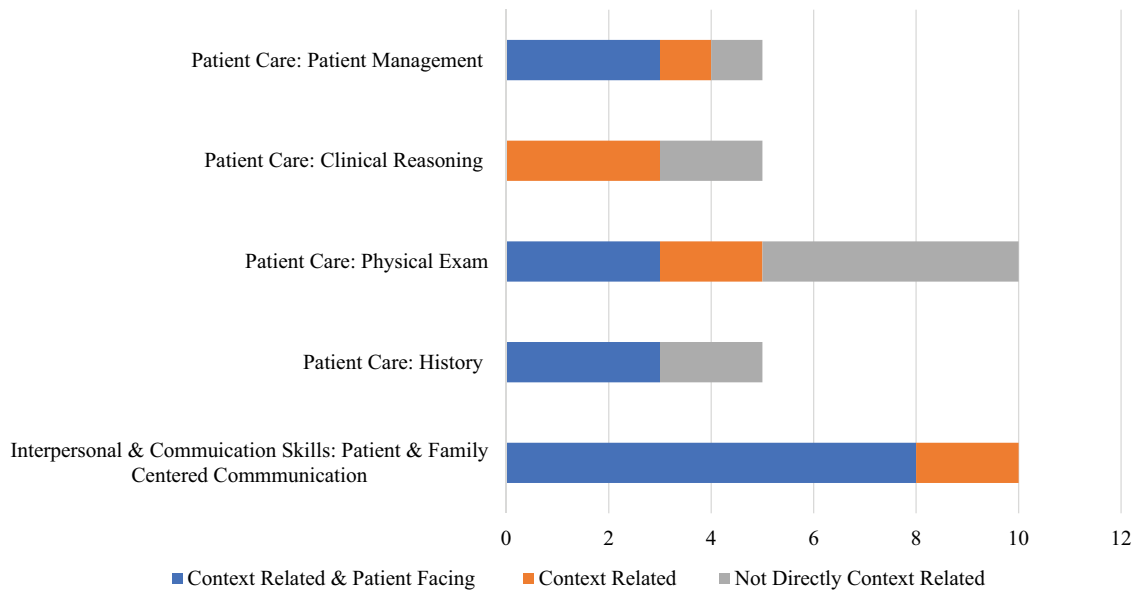


Figure 3. Number of context-related & patient-facing milestones specific to patient communication sub-competencies: internal medicine.

jump right into smoking cessation counseling with this patient. Skipping this step misses understanding the critical function of smoking within this patient’s current context. For this patient, smoking is a primary tool for anxiety and stress management and is likely helping the patient cope with undiagnosed posttraumatic stress disorder. Knowing the context would lead the clinician to recognize that now actually might not be the best time to engage in a smoking cessation conversation, and that this would be better introduced after the patient is linked with a behavioral health clinician.

Patients *know* and *feel* when their healthcare visit is prioritizing the needs of the clinician, healthcare system, or insurance companies, rather than their own. Healthcare visits can feel like 15 minutes of to-do items and box checking of which the topics may or may not be of primary concern to the patient. To be clear, this is absolutely a system-level, electronic medical record (EMR)- and insurance-driven reality; it is not clinician driven. Primary care clinicians are under intense pressure around documentation, EMR demands, and quality metrics [31,32]. In fact, increased EMR demands among other box-checking activities are a source of

## Pediatrics: Patient Communication Related Sub-Competencies



**Figure 4.** Number of context related & patient-facing milestones specific to patient communication sub-competencies: pediatrics.

burnout for practicing primary care clinicians [33]. Primary care serves many vulnerable populations including people experiencing health inequalities, chronic medical conditions, mental health disorders, substance use disorders, and ever increasing financial and social health adversities. We need to ensure that the approach we use to learn about our patients' social context is not focused on completing a checklist, but rather is a relationship-centered, conversational approach that allows for a genuine connection between patient and health care clinician.

The CI provides a framework and incorporates a philosophy that allows the pertinent information gathering process to be conversational and to promote genuine connection. The CI is anchored in four major life domains, including the areas of Love, Work, Play, and Health Behaviors (Table 3). It allows clinicians to understand they are interacting with a human being rather than a patient. The CI can aid providers in the monumental task of understanding the patient's life context outside of the medical visit, a context that is ever changing and should greatly impact healthcare clinicians' decisions and recommendations. The CI can help clinicians answer the question, 'How do I need to tailor my communication and approach to health care interventions, so they are practical and applicable to this specific person's everyday social context?' Ultimately, this structure helps the clinician formulate interventions and treatment plans germane to, and inclusive of, the patient's context. The method of this interview approach is meant to be conversational, yet intentional. While the clinician is gathering information regarding the patient's context with a sense of

curiosity, they are simultaneously using this information to guide their subsequent questions. The CI can be applied generally (i.e., health maintenance visit) or can connect to a specific presenting problem. Relevant information related to the CI may also be collected over multiple visits, and importantly needs to be revisited routinely over time.

While the LWPHb mnemonic anchors the interview, the other essential element of the CI is actively listening for social health challenges, barriers, and disparities, guided by the ACCESS-V mnemonic (Table 3), which was developed by two of the authors for clinical training purpose [34]. The ACCESS-V mnemonic covers well-established and deeply researched social health factors such as exposures to adverse childhood events (ACEs) [35]; cultural considerations [36]; internal events related to health and wellbeing (i.e., thoughts, emotions, associations, memories, physical sensations) [37]; external circumstances, situations, or relationships (e.g., current hardships and traumas, social support) [37]; exposures to SDoH and effects of structural oppression [2,4,38]; key information about motivation and stages of change related to health behaviors [39,40]; and finally the patient's values [41] and what matters most to them. All of these factors may influence a person's ability to access healthcare, understand and comprehend health-related information, make treatment decisions, establish trust and confidence in the medical system, follow through with treatment plans and recommendations, meet their health goals, engage in preventative health care, and manage their chronic health conditions. The CI changes information-gathering from a static and disease-focused



**Table 3.** Components of the contextual interview: love, work, play, health behaviors (LWPHb).

Contextual Interview (LWPHb)	Description	Listening for ACCESS-V
Clinicians inform the patient they want to learn about their context and 'get to know them' by asking a series of questions. Or, if re-assessing context, can state, 'get a sense of any changes in your life/situation.'		
<b>Love</b>	<p><b>Learn about the patient's living situation, relationships, and social connections.</b></p> <p><i>Who all lives in your home? Are you in a relationship? Who are the most important family members in your life? Do you have any friends you talk with or spend time with? Do you have any spiritual, religious or beliefs in general that are important to you and/or inform how you live?</i></p>	<p>As clinicians gather information about the patient's immediate life context, they are acutely listening for conditions related to the ACCESS-V Mnemonic.</p> <p><b>A = Adverse Childhood Experiences.</b> Clinicians are listening for signs or evidence of past adverse childhood events as well as incorporating how these ACEs impact their current health status.</p>
<b>Work</b>	<p><b>Learn about the patient's current education, work, career, and financial life.</b></p> <p><i>What do you do for income? What is your work or school status? What challenges do you face in finding meaningful work? (School) Do you have any favorite classes/subjects or ones that you particularly struggle with?</i></p>	<p><b>C = Cultural Considerations.</b> Clinicians are listening for important aspects related to a person's cultural context, including but not limited to traditions, beliefs, identity, etc.</p> <p><b>C = Context, Internal,</b> that relates to health &amp; health care delivery. Clinicians are listening for signs of internal distress and important frames of reference through patients' thoughts, emotions, associations, memories, and sensations (TEAMS mnemonic).</p>
<b>Play</b>	<p><b>Learn about activities the patient enjoys, how time is spent during leisure time, hobbies/interests, or any activity that brings joy or meaning.</b></p> <p><i>Do you have any hobbies or passions – or something you really like to do? When you feel most at peace, what are you typically doing? Are there things you used to enjoy doing?</i></p>	<p><b>E = Context, External</b> (including active trauma or adverse adult experiences), that relates to health and health care delivery. Clinicians are listening for key situations, circumstances, relationships that are facilitators or barriers to health.</p> <p><b>S = Social &amp; Structural Determinants of Health.</b> Clinicians are listening for barriers to basic human needs and SDoH, including conditions related to where patients are born, live, learn, work, play, or worship, as well as key demographic data (i.e., race, ethnicity, gender identity, sexual orientation) that increase likelihood of exposure to structural inequities.</p>
<b>Health Behaviors</b>	<p><b>Learn about the context of current health behaviors including: substance/alcohol use, diet and nutrition, physical activity, and sleep. A focus on curiosity not judgment and an understanding that 1) substance use often serves an important function in people's lives; and 2) health behaviors such as sleep, diet, and physical activity may not be as feasible or easily accessible for some people due to SDoH factors.</b></p> <p><i>Do you drink any caffeine? Use any products with nicotine? Do you use alcohol or other substances? Do you find that your use of [substance] helps cope with stressors you are facing? What does the [substance] help with? Do you follow any specific diets or eat more of a convenient diet? Many people find it really hard to get quality sleep and physical activity, what challenges do you face?</i></p>	<p><b>S = Stage of Change.</b> For relevant health behaviors, clinicians are listening for the patient's ability or desire to change behaviors for health benefits, as well as readiness for change and motivations for change, with special attention towards interplay of all aspects of ACCESS-V.</p> <p><b>V = Values.</b> Clinicians are listening for what matters most to the patient, including their values and aspects of their life that are most important and meaningful.</p>
Finally, and when relevant, clinicians should take the time to verbalize validation that a certain aspect of the patient's health has been hard to manage or that their presenting problem 'makes sense' based on their context/situation.		

process to a dynamic and contextually focused process, which allows the patient's biopsychosocial context to contribute to treatment decisions and iterate subsequent treatment plans based on new contextual information.

### Conclusions and future directions

Patient interviewing needs to evolve to more accurately reflect the influence of structural, circumstantial, and environmental factors on health, illness, and engagement in healthcare. This paper encourages the adoption of a patient-interviewing framework that prioritizes appreciation of a patient's social context, the understanding that this information is dynamic, and the utilization of contextual data to inform more patient-centered and context-sensitive treatments. Our review of the ACGME Milestones supports the need for patient-clinician interviewing and communication

skills that target social context. While the CI has primarily been used by mental health clinicians working in integrated healthcare settings, we are advocating for educational research to promote the use of the CI in undergraduate and graduate medical education and to clarify core learning objectives and metrics. These objectives will then contribute to the development of training materials (e.g., case studies, workshops, observation checklists) for CI skill development within medical education. Research can then shed light on the degree to and manner by which CI training affects learner skill acquisition and competency development, as well as evaluating the response of patients who are exposed to the CI. The dissemination of CI practice may especially benefit patients whose physical and mental health-related challenges are affected by structures of oppression like racism and social forces of exclusion based on race, ethnicity, religion, sexual orientation, gender identity, etc. Educational research is needed to

determine the extent to which CI training can help meet the goals of inclusive and anti-racist initiatives within medical education. The core elements of the CI emphasize eliciting patients' unique social context, thereby acknowledging that not all individuals living in the U.S. experience the same provision of healthcare services. We must honor the complexity that undergirds our patients' vulnerability to certain health behaviors, barriers, and outcomes. One approach is to sew the concept of *knowing a patient's social context* into the fabric of one of the most basic skills of being a healthcare clinician: patient interviewing.

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