

Debate & Analysis

The IMPACT Q framework:

teaching medical students how to gather a psychosocial history

INTRODUCTION

Many patient visits in primary care are driven by psychosocial concerns¹ and medical illness is invariably linked to these. Yet when we teach undergraduate medical students to explore such psychosocial issues in the standard social history, in practice this often comprises a limited number of questions relating to smoking, alcohol, and occupation. Junior doctors, trainees, and students infrequently ask about the impact of an illness or problem on issues such as the patient's ability to provide for themselves or on the psychological impact. These questions are more meaningful to patients than being asked about their use of recreational drugs or cigarettes in the traditional social history, where such psychosocial issues are often explored and contained near the end of a patient's history. Failing to ask these important questions relating to impact of a problem on a patient's life, in a natural and fluid way throughout the history, can lead to a disconnect between the clinician and patient agenda. Furthermore, this disconnect can make it difficult to move towards approaches such as shared decision making, management plans, and self-care, which are all essential outcomes in the current NHS.

It is hoped that, by encouraging a more natural and reflexive questioning style to emotive psychosocial issues, students will be able to really listen, understand, and react to these feelings in an appropriate way in real time. The current history-gathering template is therefore at risk of contributing to the so-called 'empathy erosion' where there is a decrease in compassion and empathy in clinical medical students, as they start viewing patients as cases needing to be medically managed, with psychosocial issues often shackled to the social history tagged on to the end of the encounter. This article aims to address the imbalance of biomedical versus psychosocial enquiry in current clinical history gathering, and present a new tool as a potential solution.

STUDENT EMPATHY EROSION

Having observed students consulting with real patients and actors during examinations and training, the lack of empathy among some students is often sadly evident. Patients talk of distress and they do not get acknowledgement for this, with students

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feeling they must wait for the social history near the end to nominally return to these issues. Students begin to feel that demonstrating empathy is a tick-box exercise for both themselves and the examiner, whereby they make generic statements referring to the well-known ideas, concerns, and expectations (ICE) criteria, such as *'that must be terrible for you'* or something inappropriate such as *'that's great — what do you do for a living?'* after a patient discloses that their father died of lung cancer. For some, this reveals a lack of understanding of when or how to explore these very real patient emotions in a human way. For others who do have this understanding, the challenge of how to delve deeper into these emotions within the constraints of the current history format become apparent.

Clinical empathy is a vital element for the delivery of good health care.² This has been defined as 'affective', relating to the ability to resonate emotionally with the patient,² and 'cognitive', relating to recognising and understanding a patient's experience, then relaying this back to the patient and taking appropriate helpful actions in response.³

The theory of empathy or ethical erosion through the course of medical training is well documented⁴ and is where students' ability to empathise with their patients actually declines with clinical exposure. Studies have suggested that doctors respond to patients with *'detached concern'*⁵ offering little emotional support with more focus on the biomedical enquiry.⁵ This reduction in clinician empathy has been linked to higher patient anxiety and stress, reduced patient satisfaction and enablement, and poorer clinical outcomes.⁶ Theories on causation of ethical erosion in medical students include unrealistic expectations, poor role modelling and mistreatment from seniors, lack of support, workload pressure, and unsuitable learning environments.⁷ We propose to add another causal factor among this suggested list of empathy eroders: the traditional medical clerking.

A NEW FORMAT FOR THE MEDICAL STUDENT HISTORY AS A POTENTIAL SOLUTION

We speculate that the current history-gathering format plays an important role in eroding student empathy by focusing on making a diagnosis, without also formally encouraging students to listen to how patients' lives are being affected by their problems. Students often feel lost, caught between their natural conversational skills and this new way of interacting with patients that they have been taught through history gathering. It has been recognised that students do not feel confident or comfortable in taking a psychosocial history,⁸ which may be attributable to the fact that teaching and assessment are so focused on clinical data gathering.

When learning to perform a complex skill an instructional framework can be useful, such as 'mirror, signal, and manoeuvre' when learning to drive. Using instructional techniques have also been shown to be effective learning tools for history-gathering with patients.⁹ At an early stage of their training, students often rely on history gathering structures to allow them to frame their questioning. For example, the SOCRATES mnemonic (site, onset, character, radiation, associations, timing, exacerbating/alleviating factors, and severity), commonly used for remembering to ask questions pertaining to pain, is highly effective as a learning tool. The literature is generally supportive of mnemonics as a learning strategy for medical students.¹⁰

The IMPACT Q tool (Box 1) is a simple mnemonic framework we have developed to facilitate the students thinking about the potential impact of a problem on the patient's life, fostering a culture where the students' enquiry into these domains is not only permissible but also recommended. This has been informally trialled with some third-year medical students in a primary care setting, where they elicited information they felt they would otherwise have never enquired about

Box 1. The IMPACT Q tool

What is the impact of a clinical problem on the patient's ... ?

I — Ideals	How has this all impacted on how/where you would ideally like to be right now?
M — Mood	How has this affected your mood?
P — Provisions for self/family	Has this impacted on your ability to provide for yourself and your family?
A — Ambitions	Has this impacted on any of your ambitions or goals?
C — Capability/caring roles	How is this impacting on your ability to care for your children/family/self?
T — Tasks/traditions	Are you able to carry out everyday tasks and traditions?
Q — Quality of life	How is this having an impact on your general quality of life?

had they not used the IMPACT Q framework. An example was a female patient with arthritis whose biggest issue was being unable to care for and play with her grandchildren.

This tool would be designed to be used flexibly with patients who are seen by the student, with each of the areas explored to different degrees according to the problem within the history of each presenting complaint. We propose that the use of such a tool will not only enrich the psychosocial enquiry, but also encourage students to ask these meaningful questions throughout a history, not just limiting them to a cursory glance at the end.

The hidden curriculum in medical students denotes '... *unscripted learning occurring outside the formal, taught curriculum*'.¹¹ Currently little is taught on history-gathering techniques relating to psychosocial impact of illness. By exposing this through patient interactions, we hope the use of this tool will normalise psychosocial questioning and allow students to connect and empathise with their patients as they gain confidence in asking such questions as part of their standard history gathering.

There is evidence that recognising patient emotion and psychosocial issues early in the clinical encounter can decrease the number of new problems that may emerge in the final moments of the visit.¹² It is postulated that if students learn to adopt this new approach it could also have a direct impact on health outcomes, patient satisfaction, attendance, and expenditure as patient's agendas are increasingly listened to and addressed.¹³

Just as other medical mnemonics are widely adopted for initial learning until they are deeply engrained, the use of IMPACT Q will eventually help our future doctors master the ability to concurrently elicit both medical and psychosocial information, allowing both doctor and patient to feel a sense of connectedness to each other. By bringing the patient's life story to the forefront, it is hoped that this will result in

better clinical practice, patient satisfaction, and health outcomes. Students sometimes report a lack of confidence in their medical knowledge, which they perceive as inadequate for them to have a meaningful role in the care of a patient. By placing more importance on humanistic skills, students may feel more at ease speaking about psychosocial issues and therefore more empowered and valued. This in turn could positively influence the development of their professional identity and contribution to their team.

FUTURE PLANS WITH IMPACT Q

Students will be taught this new approach to history taking during centralised teaching sessions. We plan to formally evaluate the framework, exploring whether it has an impact on student empathy and professionalism, and on patient satisfaction. It is also important to ensure this approach is encouraged by senior faculty and more widely by doctors who remain important role models for our students and trainees.

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Provenance

Freely submitted; externally peer reviewed.

Competing interests

The authors have declared no competing interests. This article presents independent research supported by the National Institute for Health Research (NIHR) under the Collaborations for Leadership in Applied Health Research and Care (CLAHRC) programme for North West London. The views expressed in this publication are those of the

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authors and not necessarily those of the NHS, the NIHR, or the Department of Health.

Acknowledgements

The authors would like to thank Prof. David Hirsh, Mr Martin Lupton, Dr Sonia Saxena, and Prof. Roger Jones.

DOI: <https://doi.org/10.3399/bjgp17X694349>

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