ISSN: 1815-7696 | RNPS: 2057 | Mendive. Journal on Education. Vol. 24, e4702
Díaz Calzada, M.; Herrera Miranda, G. L.; Fuentes Reinoso, A.; Cecilia Paredes, E. E. "The development of interviewing skill in the teaching-learning process of the subject Health Promotion: systematization".
https://mendive.upr.edu.cu/index.php/MendiveUPR/article/view/4702

2026

Review article

The development of interviewing skill in the teaching-learning process of the subject Health Promotion: systematization

La formación de la habilidad entrevistar en el proceso enseñanza-aprendizaje de la asignatura Promoción de Salud: sistematización

A formação da habilidade de entrevistar no processo ensino-aprendizagem da disciplina Promoção da Saúde: sistematização

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Received: 28/06/2026
Accepted: 3/09/2026

ABSTRACT

The teaching-learning process of the Health Promotion subject in Medical School demands pedagogical approaches capable of articulating theory with clinical and interactive performance from the initial cycles. Within this formative framework, the family and community medical interview constitutes the fundamental operational tool of the clinical-epidemiological method in Primary Health Care. The objective was aimed at systematizing the theoretical, methodological, and historical-didactic foundations that support the process of training the ability to interview individuals and families in the undergraduate Medical program in Cuba. The main methods were at the theoretical

level, such as analytical-synthetic, inductive-deductive, and historical-logical, complemented by a literature review and document analysis of curricular study plans, international medical education guidelines, and indexed scientific literature. As results, it was determined that the development of the interviewing skill evolved an integrated and student-centered curricular design, where education at work and early clinical simulation acted as essential drivers. Likewise, the invariants of core communicative skills (expressing, observing, listening, and empathizing) were identified, alongside the relevance of structuring the didactic action through stages of orientation, assimilation, and systematization within the real scenarios of community care. As conclusions, the scientific training of the interviewing skill is consolidated as a pedagogical and practical construct indissoluble from the clinical method in Cuba. Its progressive and gradual acquisition during undergraduate studies guarantees that future general practitioners respond in a humanized, pertinent, and ethically rigorous manner to the complex health demands of contemporary society.

Keywords: medical education; medical interview; skill training; health promotion; didactic systematization.

RESUMEN

El proceso de enseñanza-aprendizaje de la asignatura Promoción de Salud en la carrera de Medicina demanda enfoques pedagógicos capaces de articular la teoría con el desempeño clínico e interactivo desde los ciclos iniciales. En este marco formativo, la entrevista médica familiar y comunitaria constituye la herramienta operativa fundamental del método clínico-epidemiológico en la Atención Primaria de Salud. El objetivo estuvo dirigido a sistematizar los fundamentos teóricos, metodológicos y la evolución histórico-didáctica que sustentan el proceso de formación de la habilidad entrevistar a personas y familias en el pregrado de Medicina en Cuba. Los principales métodos fueron del nivel teórico, como el analítico-sintético, el inductivo-deductivo y el histórico-lógico, complementados con la revisión y el análisis documental de planes de estudio curricular, directrices internacionales de la educación médica y literatura científica indexada. Como resultados, se determinó que el desarrollo de la habilidad entrevistar evolucionó hacia un diseño curricular integrado y centrado en el estudiante, donde la educación en el trabajo y la simulación clínica temprana actuaron como dinamizadores esenciales. Asimismo, se identificaron las invariantes de las habilidades comunicativas basales (expresar, observar, escuchar y empatizar) y la relevancia de estructurar la acción didáctica

mediante etapas de orientación, asimilación y sistematización en los escenarios reales de la atención comunitaria. Como conclusiones, la formación científica de la habilidad entrevistar se consolida como un constructo pedagógico y práctico e indisoluble del método clínico en Cuba. Su adquisición progresiva y gradual en el pregrado garantiza que el futuro médico general responda de forma humanizada, pertinente y con rigor ético a las complejas demandas sanitarias de la sociedad contemporánea.

Palabras clave: educación médica; entrevista médica; formación de habilidades; promoción de la salud; sistematización didáctica.

RESUMO

O processo de ensino-aprendizagem da disciplina Promoção da Saúde no curso de Medicina exige abordagens pedagógicas capazes de articular a teoria com o desempenho clínico e interativo desde os ciclos iniciais. Nesse marco formativo, a anamnese médica familiar e comunitária constitui a ferramenta operativa fundamental do método clínico-epidemiológico na Atenção Primária à Saúde. O objetivo esteve dirigido a sistematizar os fundamentos teóricos, metodológicos e a evolução histórico-didática que sustentam o processo de formação da habilidade de entrevistar pessoas e famílias na graduação de Medicina em Cuba. Os principais métodos foram do nível teórico, como o analítico-sintético, o indutivo-dedutivo e o histórico-lógico, complementados com a revisão e análise documental de planos de estudo curriculares, diretrizes internacionais da educação médica e literatura científica indexada. Como resultados, determinou-se que o desenvolvimento da habilidade de entrevistar evoluiu um desenho curricular integrado e centrado no estudante, onde a educação no trabalho e a simulação clínica precoce atuaram como dinamizadores essenciais. Da mesma forma, identificaram-se as invariantes das habilidades comunicativas básicas (expressar, observar, ouvir e empatizar) e a relevância de estruturar a ação didática mediante etapas de orientação, assimilação e sistematização nos cenários reais da atenção comunitária. Como conclusões, a formação científica da habilidade de entrevistar consolida-se como um construto pedagógico e prático indissociável do método clínico em Cuba. Sua aquisição progressiva e gradual na graduação garante que o futuro médico geral responda de forma humanizada, pertinente e com rigor ético às complexas demandas sanitárias da sociedade contemporânea.

Palavras-chave: educação médica; entrevista médica; formação de habilidades; promoção da saúde; sistematização didática.

INTRODUCTION

The subject of Health Promotion, in its role as a cornerstone of medical education, demands a teaching-learning approach that transcends the mere transmission of content. A solid pedagogical framework for this discipline must be grounded in theories that recognize the complexity of learning in applied contexts and the dynamic nature of public health.

Contemporary authors such as Biggs and Tang (2011), through their constructive alignment model, propose that instructional design should coherently link expected learning outcomes, teaching activities, and assessment strategies. Applied to Health Promotion, this implies that activities are designed to foster the development of specific competencies within the discipline and that assessment accurately evaluates the achievement of those competencies.

From a social constructivist perspective, Vygotsky (1980) established that learning is a process mediated by social interaction and culture. In Health Promotion, this conception highlights the importance of creating collaborative learning environments where students discuss, negotiate meanings, and jointly construct knowledge, replicating the dynamics of interdisciplinary work and community participation characteristic of this field. Similarly, Rogoff (2003) expanded on these ideas by conceiving of learning as guided participation, in which the teacher and more experienced peers play an essential role in facilitating the student's progress within their zone of proximal development. Consequently, the teaching of complex skills, such as interviewing in Health Promotion, benefits from methodologies based on observation, guided practice, and continuous feedback.

Furthermore, the self-determination theory developed by Deci and Ryan (2000) offers a relevant perspective for medical education. According to these authors, intrinsic motivation, fundamental for promoting deep and lasting learning, depends on the satisfaction of three basic psychological needs: autonomy, competence, and relatedness. In the subject of Health Promotion, this implies designing educational experiences that allow students to make decisions, develop confidence in their abilities to face complex challenges, and establish meaningful connections with the content, instructors, and their peers.

Furthermore, Kolb's (2015) experiential learning theory highlights the role of concrete experience and critical reflection as fundamental drivers of learning. In this context, it is essential to incorporate practical activities, such as interview simulations, community case studies, and the design of health interventions, that allow students to confront real or simulated situations, reflect on them, conceptualize new knowledge, and implement improved strategies.

In summary, a robust framework for the teaching and learning process in Health Promotion must integrate, in a coherent manner, the principles of constructive alignment, social constructivism, self-determination theory, and experiential learning. The rigorous application of these theoretical frameworks enriches the understanding of the educational process and fosters the training of professionals capable of responding effectively to the complex demands of contemporary public health.

DEVELOPMENT

General conception of skills in the teaching-learning process

Skills enable humans to perform a specific task by executing actions that are gradually refined through practice and experience. This developmental process is directly related to the concept of activity as the foundation of human development. In this regard, Leontiev (1993) argues that human activity is structured around actions that, when repeated and consciously systematized, allow for the formation and consolidation of skills. This process involves the holistic development of the individual in their educational, instructional, and developmental dimensions, achieving the progressive transformation of experience into truly meaningful knowledge. Based on this, Kolb (2015) emphasizes that learning is constructed from concrete experience, which is transformed through reflection into new ways of acting.

In higher education, the system of logical-intellectual skills is fundamental, taking on particular relevance in the field of medicine, where communication and the doctor-patient relationship constitute essential competencies. According to the postulates of Biggs and Tang (2011), university teaching should be oriented toward the development of integrated learning outcomes and professional competencies, so that students acquire modes of action that allow them to transform the object of study and solve professional problems. From a sociocultural perspective, Vygotsky (1980) argues that the development of these higher mental functions occurs through the

internalization of social processes mediated by interaction. Thus, skill can be understood as " knowing how to do," which results from the systematization of conscious, goal-oriented actions.

From this perspective, personality development is determined by social and cultural interaction in shared contexts. According to Rogoff (2003), human development is a culturally situated process mediated by participation in social activities. Since human activity is organized into basic actions that constitute the foundation of learning, Leontiev (1993) emphasizes that action is the essential component of activity; therefore, it is through the repeated and conscious execution of these actions that the student refines their abilities in practice.

To achieve this goal, the pedagogical process must be consciously and systematically organized. In this regard, Álvarez de Zayas (1999) points out that teaching should integrate education and instruction to develop skills. This systematic practice leads to the progressive automation of actions, improving the accuracy and efficiency of performance. As Leontiev (1993) explains, repetition and practice lead to the consolidation of skills, transforming them into systems of actions and operations that flexibly adapt to the specific conditions under which the task is performed.

Therefore, skills can be addressed in an integrated way from psychological and pedagogical perspectives as conscious forms of action oriented towards educational goals. To achieve this, Biggs and Tang (2011) emphasize the need for a curriculum design that promotes the progressive integration of knowledge and disciplines from the earliest years of education.

One of the most effective methodological approaches to fostering this progress is the use of the Zone of Proximal Development, which represents the distance between what a student can do independently and what they are capable of achieving with the help of more capable peers. Vygotsky (1980) demonstrates that learning occurs in this zone through social mediation. Methods such as problem-based learning allow for the strategic orientation of training toward real-world professional situations, promoting complex skills such as clinical interviewing. As Silverman *et al.* (2013) point out, clinical communication is a core skill in medical practice. In short, skills constitute ways of assimilating human activity, developed progressively through conscious practice and ultimately aimed at solving professional problems.

Epistemological and theoretical foundations of interviewing skills: from theory to practice

Within higher medical education, skills are conceptualized as the mastery of a complex system of mental and practical actions that allow for the rational regulation of activity, based on knowledge, values, habits, and other skills of the individual. From the perspective of Cuban pedagogy, skills are an integral part of the content of the teaching-learning process, understood as the component that realizes the educational objectives through the organization of knowledge and modes of action. In this regard, Álvarez de Zayas (1999) points out that educational content integrates those elements essential for achieving the training objectives, emphasizing that in higher education, the fundamental skills should be those directly linked to professional practice, without excluding the development of thinking, communication, and information processing skills.

At the institutional level, the Cuban Ministry of Education (1976) has defined skills as components of activity that enable the successful completion of tasks, with special emphasis on the student's ability to apply knowledge to solve theoretical and practical problems. In line with this approach, González Serra (n.d.) posits that a skill constitutes "know-how," understanding it as the conscious mastery of mental and external actions that allow for the regulation of activity. For his part, Petrovsky (cited by Brito Hernández, n.d.) defines a skill as the mastery of a complex system of mental and practical actions for the rational regulation of activity, based on the integration of knowledge and habits for the conscious execution of the action.

For students to achieve true technical mastery, Sixto Fuentes (n.d.) argues that systematization of their operations is required, in accordance with the theory of the activity. In the specific context of medical sciences, these professional skills are not developed in isolation; rather, they are structured based on the disciplines of professional practice and are progressively integrated into the general curriculum until they constitute modes of professional action corresponding to the physician's functions established in Curriculum E of the Medical degree program.

Skills development as a process and its classification

Skills development unfolds through didactic stages designed to guide the teaching-learning process from motivation to evaluation. According to Rivera Michelena (n.d.), this formative transition occurs gradually and in a structured manner through the phases of orientation, assimilation, mastery, and systematization, progressing from exploration to application in new situations. During this

progression, actions become progressively conscious, and through practice, their components are automated, significantly improving the accuracy and efficiency of performance. As Leontiev (1993) explained, systematic practice transforms action into an increasingly automated process, allowing us to differentiate between skill and habit; habits tend to be automated, while skills always involve conscious regulation.

To avoid the entrenchment of errors in skill acquisition, Rivera Michelena (n.d.) points out that proper pedagogical guidance and adequate initial orientation are essential, complemented by sufficient and varied practice. Therefore, practice should be organized as a system of tasks with increasing levels of complexity that promote the learner's progressive development. Likewise, this learning environment should foster the creation of learning situations that encourage the student's progressive autonomy, moving from dependence to cognitive independence. Following Vygotsky's principles (1980), this learning is optimized within the Zone of Proximal Development through teacher mediation.

Finally, within medical education, Rivera Michelena (n.d.) classifies skills into teaching, logical-intellectual, logical-dialectical, and profession-specific skills, all of which are geared toward developing professional competencies in medicine. The profession-specific skills are strictly oriented toward the physician's mode of practice, encompassing clinical and epidemiological methods, as well as techniques and procedures for comprehensive healthcare. According to the Medical Curriculum E, these professional skills accurately reflect the functions assigned to physicians in society.

Characteristics and trends in the development of interviewing skills in the teaching-learning process

In medical education, the relationship between instruction and education takes on a fundamental dialectical character. Ilizástigui (2000) categorically emphasized that when one teaches, one educates, and when one educates, one teaches, forming a binomial whose dialectical pair is impossible to separate. From this perspective, medicine does not study humankind as an entity abstracted from surrounding conditions, but rather as a being who lives within specific socio-economic conditions, which exert a necessary influence upon them. This underscores the importance of the clinical method and the need to train students to interview patients correctly, to ensure quality in the preparation of medical records, and to create strategic alliances among the different levels of healthcare.

This approach reflects a profound transformation in healthcare models. The old pattern of healthcare, centered on illness, delivered in hospitals by specialized personnel, and characterized by discontinuous, fragmented, and dehumanized medical care, is being reconsidered.

The underlying biomedical, reductionist, dualistic, and scientistic paradigm is evolving toward a broader and more inclusive one, restoring humanity and health to the center of medical care. However, the introduction of these innovative changes to the healthcare system and the consolidation of a new medical culture often encounter barriers and obstacles within medical schools, which have traditionally relied on biomedicine and individual medical practice as their primary drivers of leadership.

Throughout the 20th and 21st centuries, numerous international events and summits on medical education have analyzed physician training. These forums have emphasized the need for training to be less theoretical and more closely linked to real-world medical practice to ensure the acquisition of professional competencies, particularly in Primary Health Care (PHC), a setting where various studies demonstrate difficulties in skills development due to insufficient pedagogical and didactic preparation of tutors.

The development of Latin American thought in the 1970s deepened the relationship between medical education and social structure, recognizing the dominant role of the organization of medical care on the process of human resource development and the determining role of the structure of the labor market and medical practice.

According to Del Llano *et al.* (2023), in line with the above, preparation requires a deep mastery of both theoretical knowledge and the professional skills necessary for professional practice. With an equally critical view of medical education, Ilizástigui (2000) maintained a firm stance regarding the limiting aspects of student training, pointing out problems such as the encyclopedic nature of the programs, the theoretical overload that prevents students from grasping the essentials, the predominance of passive teaching methods—such as lectures versus work-based learning, the technical-biological versus the biopsychosocial approach, the Flexnerian curriculum model, and the fragmentation of subjects compared to integrated designs.

Likewise, Ilizástigui (2000) criticized the tendency to place greater emphasis on abstract research and specialized medicine, a phenomenon that promotes the segmentation of teaching by specialty,

consequently distorting the professional model. Although the stated purpose is to train general practitioners, in reality, teaching is carried out by specialists and from within their respective fields. Similarly, he criticized the insufficient emphasis on the community as a training setting, as well as the deterioration and inadequate supervision of basic clinical skills in practice.

Given these limitations, current trends demand a transition in which instruction based on passive methods gives way to more modern methods oriented toward the active participation of students in small groups (seminars, group discussions). Thus, teaching shifts from teacher-centered to student-centered, where the teacher actively participates as a guide or facilitator. It is precisely the knowledge acquired that allows the student to act as a professional and enables them to continue autonomously in the subsequent stages of their learning. Continuing education will have a solid foundation in this initial knowledge, understanding that medical education constitutes a continuous process throughout the professional's life.

In the analysis of technical performance, it is observed that physicians generally demonstrate favorable development in the skills of expressing themselves, observing, listening, and being empathetic—elements that represent an important part of achieving interviewing skills. However, students must learn with principles and invariants structured around how medical practice is carried out and the health needs of the individual, the family, and the community. In this sense, the clinical method is simply the scientific method applied to working with patients, where the most important condition for teaching medicine is its objectivity, guaranteeing the student's real contact with the subject of study from the very beginning of their career, while taking into account Hippocratic and ethical principles.

Paradoxically, current medical practice has become technically impoverished. Frequently, the patient's clinical reality is not captured, nor are thorough medical histories compiled to adequately characterize the individual with a disease and the pathological process itself. There is little communication with patients, good doctor-patient relationships are not established, physical examinations are incomplete or omitted, diagnostic hypotheses are not formulated, and scientific prognoses are not established, with an excessive reliance placed on the value of complementary tests and high technology to identify the lesion of the disease process. Given this situation, it is imperative to demonstrate that correctly interviewing patients using the clinical method is a fundamental pillar of the profession. Today, as in the past, but for different reasons, a renewed call

is needed for physicians and other healthcare professionals to return to fulfilling the Hippocratic legacy of bedside education; yesterday it was necessary because there was little scientific knowledge, today it is necessary because there is too much fragmented technology.

These concerns were reflected internationally during the World Summit on Medical Education held in 1993, where the Edinburgh Declaration was issued, a document that formulated essential recommendations to guide medical education worldwide (World Health Organization, 1993). Among the trends identified, which respond to the demands that society places on medical universities, the following are noted:

- The concern for the quality of higher education: conceived as one of its main inherent concepts. Although quality is essentially linked to social relevance, in the quality of teaching, the conception, design, and operational development of curricula are directly considered.
- The integral formation of the student: structured in such a way as to promote the development of the human being as a whole and favor his personal growth, his autonomy and his socialization, together with the strengthening of the formation of values.

These trends demonstrate that global changes in medical education are geared towards training physicians for primary care who are capable of providing comprehensive care. In their daily work with patients, physicians use three basic methods to obtain the information necessary for diagnosis: the patient interview, the physical examination, and complementary studies. It is precisely the patient interview that contributes most to clarifying the diagnostic problem. Consequently, the professional training model of the University of Medical Sciences considers communication skills an essential requirement. When interviewing a patient, a group of fundamental skills must be addressed as a priority: the skills of expressing oneself, observing, listening, and establishing an empathetic relationship. The systemic conception of skills, and within them the skill of interviewing, implies their analysis based on the essential consideration that there is an indissoluble dialectical relationship between the system of skills and the system of knowledge, which ensures that these two systems are in no way interpreted as independent or parallel.

The process of developing the ability to interview individuals and families in the training of general practitioners worldwide

Education is a process aimed at the holistic development of human beings, which means maximizing their motor, cognitive, personal, and social potential so they can fully exercise all their faculties in every aspect of life. Analyzing human history reveals that many conflicts and disagreements among people stem from an inability to create and maintain healthy relationships. Therefore, complex links exist between education and social development, underscoring the current need for educational systems to respond to the social demands of the 21st century. This is expressed in the studies of Salazar *et al.* (2014), who, in line with the above, consider communication to be an essential competency in medical training today.

A significant finding by the author in analyzing documents related to interviewing skills worldwide is that medical education is separated from medical practice in most countries. This separation has historically been considered problematic, given the need for genuine integration and coordination between the two spheres. Methodologically, the impact of the educational model recommended by Flexner (1910), which has remained unchanged for over a century, continues to be evident. This approach separates theory from practice during the first two years of undergraduate studies; therefore, interviewing skills are not formally taught until the third year of medical school in much of the world.

The launch of the Primary Health Care (PHC) renewal is largely a response to the fact that many countries in the Americas are experiencing social exclusion in health. Analysis of the determinants of health and their influence on human development, as well as the necessary transformations of health systems, has led to a consensus that PHC remains the primary and most effective strategy for promoting health and achieving the highest possible level of health for every person. In this strategy, the general practitioner plays a transformative role, supported by the clinical method, which is approached from different perspectives (World Health Organization, 2008).

In this international context, several experiences stand out. In Mexico, for example, López-Navarrete (n.d.) considers the medical interview a fundamental pillar in the training of university students, since healthcare professionals require commitment, professionalism, and other individual skills that allow them to obtain sufficient and relevant information, representing the best communication resource between both parties. Meanwhile, the University of New Mexico, in the early 1980s,

implemented a new, strongly community-oriented program that promoted curricular integration, while maintaining the previous program as an alternative for students.

In North America, several initiatives have been implemented, both in the United States and Canada. In 1993, the University of Illinois at Rockford School of Medicine implemented a Rural Medical Education Program to train family physicians. Its aim was to select students based on their affinity for rural practice, their community-oriented training, and their rural preceptorships, in which students had direct contact with the professional practice environment. In this model, developing interviewing skills was essential, beginning in the third year of medical school.

The World Health Organization (2008) reaffirms that among the essential elements of a primary health care (PHC)-based health system are human resources, who must possess the appropriate knowledge and skills, adhere to ethical standards, and treat people with dignity and respect. This renewal requires countries to create institutional conditions for human resource development, with a constant emphasis on quality, continuous improvement, and the development of competencies appropriate for PHC.

Historically, the theoretical foundations of this concept were established at the Alma- Ata Conference (Kazakhstan) in 1978, sponsored by the World Health Organization (WHO) and the United Nations Children's Fund (UNICEF). It was established there that to implement the "Health for All by the Year 2000" policy, it was necessary to define a specific strategy, distinct from those used up to that point. This conceptual framework, whose pillars were equity, prevention, community participation, intersectoral collaboration, and the application of appropriate technologies, was formally defined as "Primary Health Care" (World Health Organization, 1978).

Following this line of thought, in 2008 the World Health Organization published a report establishing Primary Health Care (PHC) as a training ground for medical students, with students receiving direct training in the very workplace where they will work after graduation. Consequently, for several decades now, many universities have implemented curricula that incorporate courses with this focus. In Latin America, Cuba's initiatives stand out, with a strong government commitment to the development of PHC, considering undergraduate studies as the natural source of professionals and, therefore, promoting curricula aligned with this workforce need. However, the author notes that in Cuban medical offices, communication skills are sometimes addressed only superficially among

students, and that interviewing skills are not always rigorously prioritized for their professional development.

For learning the clinical method as a generalizable skill, after adequate student orientation, intensive and gradual group and individual practice is essential in all work settings that, in the Cuban context, also become teaching environments. The clinical interview is the component of the clinical method that allows for interactive communication with the patient during their care. It is a fundamental element without which providing care would be difficult and requires skills on the part of the professional that must be identified, understood, and acquired during undergraduate studies. A quality clinical interview enables the implementation of the clinical-epidemiological method, improves health outcomes, increases patient satisfaction, and enhances therapeutic adherence (Silverman *et al.*, 2013).

The process of developing the skill of interviewing individuals and families in Primary Health Care for the training of general practitioners in Cuba

The revolutionary triumph in Cuba in 1959 marked a radical shift in the existing health policy. The change in the social system provoked an exodus of doctors as a result of the initial measures, a situation that highlighted the urgent need for trained health professionals to meet the demands of the people and to educate them with a more humanitarian vision, in accordance with the principles of the new ideology (Álvarez de Zayas, 1999).

In 1962, the University Education Reform was implemented, a historically significant event in the subsequent development of higher education in Cuba, especially in the field of Medicine, with the aim of achieving superior professional performance in society. To produce a more well-rounded physician, substantial changes were necessary, and thus, the commission created for this purpose at the Faculty of Medicine began working on its profound transformation. Following the University Reform, modifications were made to the curriculum with the objective of training physicians capable of addressing the challenges of comprehensive preventive and curative medicine. In 1964, comprehensive polyclinics were established, becoming a cornerstone of community health services with the mission of Primary Health Care (PHC), in accordance with the strategy later defined by the World Health Organization (1978). Formal clinical rotations in the polyclinics began in 1966.

Successive curricula consistently emphasized the importance of training professionals who, working in primary healthcare (PHC), would provide comprehensive care, a setting where the medical interview played a crucial role. In the 1980s, the Basic General Practitioner training curriculum was implemented, revolutionizing medical education. It was with the introduction of this curriculum that the development of interviewing skills with individuals and families directly related to professional practice in PHC was explicitly declared. Also in this decade, specifically in 1984, the specialty of Comprehensive General Medicine (CGM) was established, further strengthening the social focus of medicine.

In the first decade of the 21st century, within the framework of universalizing education, a new strategy for training Cuban physicians was initiated in polyclinics as teaching settings. According to the author, during this period, interviewing skills were developed almost to their fullest potential, due to the very small student enrollments and a highly qualified faculty directly involved with families in the clinics. At this stage, the need to train and develop interviewing skills among medical students in primary healthcare (PHC) was fully recognized. Starting in 2003, a significant change was implemented, strengthening the concept of PHC and decentralizing training in polyclinics as teaching settings. Following guidance from Fidel Castro Ruz, pre-professional practice was redesigned in the 2003-2004 academic year, incorporating students into direct work in primary healthcare clinics. In the 2004-2005 academic year, the polyclinics formally became University Headquarters, experiences which, in the author's opinion, significantly strengthened the quality of the medical training process.

Since the 2016-2017 academic year, the Medicine program has implemented Curriculum E, which explicitly states competency-based training and adopts work-based learning as its guiding principle (Ministry of Public Health of Cuba, 2016). The training process has expanded as the graduate profile shifts toward that of a comprehensive general practitioner, significantly increasing the time dedicated to Primary Health Care (PHC) as a fundamental teaching setting. The current training process for general practitioners is characterized by its emphasis on developing a physician with a broad profile, a biopsychosocial approach, and a focus on PHC (World Health Organization, 2008). The author specifies that Primary Health Care (PHC) continues to be a fundamental teaching setting in the program, directly contributing to the development of professional skills, especially the ability to interview individuals and families.

Development of interviewing skills in the teaching-learning process of the subject Health Promotion

The ability to interview individuals and families requires the concurrence of other foundational skills for its development. Therefore, various subjects and disciplines must contribute to its progressive and gradual development throughout the years of study until complete and comprehensive training is achieved. In this sense, it is essential to train graduates who possess personal qualities, culture and professional skills, as expressed in their studies by Santaya *et al.* (2018).

The interview, the doctor-patient relationship, and communication are considered essential clinical skills for all physicians; these three skills, although treated independently for educational purposes, are closely intertwined. The interview is the operational means of establishing the relationship and communication with the patient, and these, in turn, directly influence the technical quality of the interview.

Proof that interviewing skills are the most important tool in medicine is that they alone produce the data necessary for diagnosis in more than three-quarters of cases, leading to more accurate diagnoses than data obtained from physical examination and laboratory tests combined. Furthermore, they generate the majority of the data needed for treatment and prevention, making them the primary means of conveying understandable information to the patient.

The contemporary medical interview is defined as a therapeutic dialogue between physician and patient, constituting the primary diagnostic method and an essential component of all therapy. Without this dialogue, therapy generally fails, especially in the case of illnesses that manifest through somatization. The importance of the interview has been particularly recognized in primary healthcare, with estimates suggesting that a general practitioner conducts, on average, between 120,000 and 160,000 clinical interviews during a 40-year active professional career.

In the curriculum, the skill of interviewing individuals and families begins to be developed in the course Introduction to Comprehensive General Medicine, which is taught in the first semester of the program and takes place directly in primary healthcare settings (family doctor's offices), where students first come into contact with the National Health System (NHS). The course methodology guides the acquisition of this skill, both in the classroom and through work-based learning, and continues this development in subsequent courses.

In the second semester of the program, the Health Promotion course actively contributes to the development of this skill by conducting educational interviews in various areas of health promotion and creating educational messages aimed at achieving health through comprehensive care for individuals and families, with the specific purpose of fostering healthy lifestyles. Subsequently, in the third semester, the Health Prevention course includes among its curricular objectives the active screening of diseases through the integrated application of observation and medical interview techniques.

Having completed these three subjects in real-world primary healthcare settings, students possess an essential foundation but require a set of complementary knowledge and skills acquired in other disciplines within the program. These disciplines provide the theoretical framework and specific skills related to their respective areas of study. In the fifth year of the program, students take the Comprehensive General Medicine course, which, within its skills framework, focuses on the definitive consolidation of the medical interview. At this point, students are pedagogically prepared to develop, with a significant degree of independence, the ability to interview individuals and families, having assimilated all the necessary content. Finally, during the rotating internship, specifically during the Comprehensive General Medicine rotation, this skill continues to be developed within the broader field of medical diagnosis, resulting in continuous refinement of their professional practice.

The medical interview has been, is, and will continue to be the first and essential step in understanding the illness and the patient. As proposed by Engel's biopsychosocial model (1977), the collection of subjective experiences such as fear and sadness is not merely superficial information, but rather hard and essential data in the medical history of any patient. The interview pursues two main objectives: first, to obtain the necessary information related to the health problems and illness of the person being treated; second, to develop a deep and professional doctor-patient relationship. This latter objective is both a goal and a requirement. The quality of the interview is currently the subject of rigorous research, due to the observed decline in physicians' questioning skills and the negative consequences this has on the entire healthcare process.

Interviewing is the most powerful diagnostic tool available to physicians and a primary source of data. It is characterized by its high complexity, as it involves the convergence of cognitive, affective, and conative factors simultaneously focused on diagnosis, the doctor-patient relationship, and treatment. It is a quintessential communication process, whose effectiveness requires mastery of the

essential methodological principles that define it and rigorous training for the professional to carry out health actions aimed at promoting health, preventing disease, and curing illness. To conduct a high-quality interview, physicians need to process a large amount of information about the patient, obtained through the medical history, questioning, and physical examination, emphasizing both subjective and objective aspects within a relational framework where the affective factor plays a crucial role.

Therefore, the interview can be formally defined as the professional encounter between the physician and the patient, constituting the temporal, spatial, and methodological framework within which most healthcare practice takes place. This process consists of several stages: reception, identification, questioning, physical examination, formulation of diagnostic hypotheses, management of complementary tests, information, therapeutic measures, and conclusion. Of these phases, the questioning is the physician's most important diagnostic tool. The medical history is the most difficult and time-consuming clinical resource to master; however, it is the physician's most powerful tool, as the diagnosis can be reached with it alone between 60% and 90% of the time, with the remainder based on the physical examination and complementary tests. Mastery of the questioning process is relevant to all clinical physicians who provide individual and continuous care to patients, assuming responsibility for their diagnosis, treatment, and follow-up, but it is especially relevant to internists and primary care specialists.

The conceptual analysis of the medical interview highlights historical contributions from various authors. Freidson (1970) considered the interview as a potentially and inherently conflictive space due to the different perspectives each participant brings to the encounter, recognizing that medicine is practiced within an organized model that directly influences the attitudes of both the patient and the physician. Waitzkin and Stoeckle (1976), for their part, conceptualized it as a micropolitical system in which the physician typically controls information to maintain traditional patterns of dominance and subordination. In contrast, current approaches interpret it as a genuine negotiation process between participants with competing perspectives, emphasizing the communicative aspect and the use of language to express what the person feels, thinks, and interprets about a crucial moment in their life: their sense of illness and their perception of vulnerability.

Developing effective interviewing skills within Primary Health Care (PHC) requires a holistic understanding that goes beyond the mechanical collection of clinical data. Various studies

demonstrate that mastering clinical communication significantly reduces diagnostic errors and fosters an environment of mutual trust, essential for therapeutic adherence (García de Alba-García *et al.,* 2022). Thus, the interview is not limited to a mere biological inquiry but rather becomes a tool for sociocultural transformation and family health education (Guzmán-Fardalez *et al.,* 2024). In this sense, the implementation of participatory pedagogical methodologies and early clinical simulation mitigates the traditional communication deficiencies identified in undergraduate studies.

Training in clinical interviewing skills is a fundamental pillar in the contemporary medical curriculum, since the interview is not only the means to establish a relationship and communication with the patient, but both dimensions directly influence the quality of care (Sogi *et al.,* 2006).

In this sense, several authors agree that communication skills have ceased to be a complement and have become a core competency of the healthcare professional, susceptible to training and continuous improvement (Molinuevo). *et al.,* 2014). The acquisition of these clinical skills by students represents an essential aspect of curriculum training, as it allows for the development of critical thinking regarding current guidelines in medical education as essential promoters for a paradigm shift (Parada-Lezcano *et al.,* 2022; Romeu & Miyar, 2015). This formative approach transcends the traditional view of the interview as a mere tool for obtaining diagnostic information and defining a therapeutic approach (Campo-Cabal *et al.,* 2006), proposing instead a relational and therapeutic model that prioritizes effective communication and empathy.

From a pedagogical perspective, various strategies have been implemented to strengthen these competencies in future doctors, among which dramatized clinical scenarios stand out, which have proven effective in teaching the doctor-patient relationship and communication skills (Jiang *et al.,* 2020).

These active methodologies respond to the need to move beyond traditional approaches and offer training experiences that integrate theory with simulated practice, allowing students to face complex situations in a safe and controlled environment. Available evidence underscores that interview training should not be limited to technical aspects, but should include the development of relational, emotional, and ethical competencies that promote person-centered care (Molinuevo). *et al.,* 2014; Sogi *et al.,* 2006).

Consequently, undergraduate medical programs face the challenge of redesigning their curricula to incorporate systematic communication training across the board, assessing not only declarative knowledge, but also practical performance and the ability to critically reflect on one's own professional practice (Parada-Lezcano *et al.,* 2022; Romeu & Miyar, 2015).

Furthermore, contemporary authors emphasize that the teaching of medical interviewing must be structurally aligned with the socio-medical needs of communities, requiring clinical tutors trained not only in clinical practice but also in medical didactics. Consequently, the consolidation of the clinical-epidemiological method in community teaching settings is directly favored when functional invariants of interactive communication are prioritized from the initial stages of the program (Rodríguez-Expósito *et al.,* 2021).

The strategic use of language and respect for the patient's subjectivity, as promoted by the biopsychosocial approach, reconfigure the interview as the fundamental pillar of quality in contemporary family medicine services (Vidal-Ledo *et al.,* 2022).

The internal articulation of the skills development process requires understanding the sequential transition of conceptual and practical actions within medical education. In this sense, research on special didactics developed by Sixto Fuentes and Márquez Marrero (2017) demonstrates that professional skills should not be conceived in an atomized or fragmented way, but rather as forms of assimilating socially conditioned activity that respond to the social mandate of the profession.

Contemporary curriculum design benefits directly when logical-intellectual skills and those specific to the practice of medicine are structured under the principles of systematization and clinical contextualization, which facilitates the student not only performing a technical operation such as questioning in isolation, but also progressively incorporating total mastery of their professional mode of action in the different teaching scenarios of the community.

Establishing an optimal doctor-patient relationship requires that the participants meet under specific conditions depending on the type of illness and the work context, whether in an emergency room, a hospital ward, a polyclinic, a doctor's office, or the patient's home. While these situations lend the interview distinct nuances, in all cases the essential stages of reception, identification, questioning, physical examination, administration of complementary tests, providing information, therapeutic

measures, and closing are clearly defined. Observing these stages facilitates the achievement of the intended objectives.

For these reasons, the author assumes that skill signifies a level of mastery of the action present in the process of obtaining information and acquiring knowledge, as well as in its use, expression, and practical application, fundamentally in the act of the medical interview. We conclude by adopting the description of Álvarez de Zayas (1999), who points out that the teaching-learning process constitutes a fundamental aspect that requires considering its essential characteristics, the principles that underpin it, and its constituent components.

In the author's opinion, the development of interviewing skills in the teaching-learning process of the Health Promotion subject is conceived as a dynamic pedagogical construct and an experiential learning tool, where the acquisition of theoretical knowledge and specific practical skills of the clinical interview act as a catalyst for the internalization of the principles of health promotion, through a meaningful, empathetic and collaborative dialogue with individuals and families, thus consolidating the learning of the subject and preparing the future professional for an effective and humanized intervention.

CONCLUSIONS

During the process of developing skills at an international level, it is essential that the teacher masters the functional structure of the skill as a methodological model that allows the skill to be deployed in its specific operations and relate them to each of the components of the teaching-learning process.

The training of doctors in Cuba is characterized by explicitly including within their professional skills the action of interviewing people and families, demonstrating a strict correspondence with the graduate profile and the professional model designed for the national health system.

The development of the ability to interview individuals and families in medical students requires a scientifically grounded process based on contemporary pedagogical and psychological theories, ensuring a gradual and structured transition.

Considering the arguments analyzed, the basic cycle, year and semester skills system is identified as the invariant of action indispensable for the formation of professional modes of action at the different levels of health care.

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Conflict of interest

Authors declare no conflict of interests.

Authors' contribution

The authors participated in the design and writing of the article, in the search and analysis of the information contained in the consulted bibliography.

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