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THE

THE EXAMINATION OF THE LONG-TERM EFFECTS OF PSYCHOSOCIAL TRAINING ON THE PRACTICE OF MEDICINE

By

Judith Swiss Lyles

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ABSTRACT

THE EXAMINATION OF THE LONG-TERM EFFECTS OF PSYCHOSOCIAL TRAINING ON THE PRACTICE OF MEDICINE

By

Judith Swiss Lyles

This study examined the long-term effects of psychosocial training on medical practice. Twenty-seven third year residents and practicing physicians who received psychosocial training in their first year of residency were interviewed using a semi-structured interview guide. Grounded theory procedures and techniques were used for data analyses. Three levels of training influence (total, partial, and minimal effect levels) were found among the residents. Residents' communicative confidence and self-awareness increased with the level of training influence. At the maximum effect level, which was the largest group, patients were viewed holistically by their physicians, the biopsychosocial model was fully integrated into medical practice, and the practice of medicine became more interesting, more challenging, and more rewarding for practitioners. Total-effect residents related the use of patient-centered skills with increases in their confidence communicating both professionally and personally. They also credited skill use with increased patient satisfaction, compliance and retention. In addition, they reported that patient-centered techniques enhanced their own satisfaction, and had helped them to grow personally. In contrast, minimal-effect residents felt that the training basically repeated what they already had been taught in medical school. They also reported using the skills far less than the other groups. Practicing physicians were most similar to total-effect residents in their integration of skills, appreciation of the training, and the benefits derived from it.

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ACKNOWLEDGMENTS

When I was growing up, one of the house rules was, "Don't start something unless you are going to finish it." The burden of that rule is one of the many reasons that this is a completed document. Another reason is the sustained support and guidance of my advisor, Katherine Miller. She is a talented scientist whose clear thinking, thoughtful suggestions, and encouragement have been invaluable. I have also had the good fortune to work with Robert Smith for the past six years. He has been a thoughtful mentor, generously contributing his time by sharing his knowledge of medical education and practice, helping me to learn interviewing techniques, and providing timely feedback--all of which contributed greatly to the success of this study. Thanks also to committee members William Donohue and Alicia Marshall for their support, insight, and suggestions.

There are two other people who directly impacted the success of this study. My sincere thanks to Jennifer Stanley for her cheerful and competent assistance on this project, and to Donald Melcer, an emeritus committee member and a wonderful teacher. My understanding of the "house rules" and of self-awareness processes, my own included, is primarily due to the learning experiences that began in his thoughtfully constructed courses. I am still learning.

Finally, I would like to thank my family, Rick and Elizabeth, for both their support and their nagging. Although theorectically I could have finished sooner without them, the truth is that I wouldn't have done it without them.

TABLE OF CONTENTS

CHAPTER ONE: INTRODUCTION

The medical interview is central to all clinical skills (Smith & Hoppe, 1991; Lipkin, 1990). Competence in interviewing is essential to diagnosis, treatment, and a healthy doctor-patient relationship. Interest in the medical interview has increased dramatically in the last two decades as researchers and educators have come to understand the relationship between communication and health. Until the early 1970s, the clinical perspective on illness was almost entirely biomedical--disease defined as "deviations from the norm of measurable biological (somatic) variables" (Engel, 1977; p.130). Beginning with Engel's call (1977) to change this perspective to a biopsychosocial model that encompasses the social, psychological, and behavioral dimensions of illness, there has been a slow, but steady, trend in medical education toward improving physicians' communication skills. This trend has been fostered, in part, by mandates from governing bodies in primary care that require residents to demonstrate competency in humanistic and psychosocial skills (American Academy of Family Practice, [AAFP], 1975; American Board of Internal Medicine, [ABIM], 1983; American Academy of Pediatrics [AAP], 1978), and by research indicating a positive association between the quality of doctor-patient communication and improved patient satisfaction, compliance, and positive health outcomes (Carroll & Monroe, 1980; Hall, Roter, & Katz, 1987; Hulka, Cassel, Kupper, & Burdette, 1976; Korsch, Gozzi, & Francis

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1968; Pendelton, 1983; Roter, 1989; Smith & Hoppe, 1991; Smith, Lyles, et al. 1995; Stewart & Weston, 1995).

The once common practice of teaching medical students history-taking by allowing trainees to observe faculty with patients has become obsolete. Although the quality, quantity, methods, and emphasis vary considerably, the majority of today's medical schools and many residencies now offer some form of structured instruction in interviewing skills (Kern, et al., 1989; Smith, Marshall, & Cohen-Cole, 1994). Most of the interview training, however, occurs in the preclinical years, before students actually see patients; once in residency, most internal medicine residents receive little or no training in communication skills (Kern et al., 1989; Merkel et al., 1990). As recently as 1990, Lipkin noted that "most physicians leave training never being observed interviewing" (p.1287), and that in spite of the new interest in research and teaching about interviewing, it remains understudied. That is, much concerning effective teaching methods, optimal curriculum content, and the impact of curriculum on medical practice remains unexplored.

In that context, it is noteworthy that a small number of progressive internal medicine residency programs have initiated psychosocial medicine courses on the post-graduate level (see Smith, Marshall, & Cohen-Cole, 1994 for a review). A major portion of these courses is dedicated to communication skills--teaching interviewing techniques and relationship-building skills. Among those that have initiated programs is Michigan State University [MSU]. In the mid-1980s, MSU medical faculty incorporated an innovative four-week psychosocial medicine rotation into the curriculum for first-year internal medicine and family practice residents. Consistent with the

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biopsychosocial model and with Stewart et al.'s (1995) newly formulated patient-centered medical model, this mandatory rotation emphasizes patient-centered medical interviewing techniques designed to elicit more accurate and complete information from patients--the patient's true story.

According to Smith and Hoppe (1991), the ideal interview is initially patient-centered: "the patient leads in areas where he or she is the expert (on symptoms, concerns, preferences, and values)" (p.470). The patient actively participates in framing the agenda. This patient-centered exchange is then followed by the physician-centered interview in which the physician leads "in his or her domain of expertise (details of organic disease and estimating probabilities of disease)" (p.470).

By first allowing the patient to control the direction of the conversation without interruption or requests for biomedical data, the physician obtains a clearer picture of why the patient has made a medical appointment. In addition, Smith and Hoppe suggest that this type of interview is more humanistic--patients become more involved, their power in the interaction increases; in turn, physicians have opportunities to express empathy and respect for the patient.

During a typical psychosocial medicine rotation, interviewing techniques are explored in theory through seminars, and in practice, through role-playing sessions and interviews (some of which are audio recorded) with patients both at hospital bedside and in outpatient clinics. Residents learn skills that help them elicit patients' agendas, address patients' emotions, manage patients' somatic complaints, and educate patients about reducing health risks. Patient-physician interviews are reviewed and discussed with feedback from both medical faculty and peers on the

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rotation. Adverse controlling behaviors such as interrupting the patient, changing the subject, using closed-ended questions, and focusing only on biomedical data become immediately apparent, particularly during audio tape review sessions. Not so apparent are the underlying reasons that residents enact these patterns during the medical interview.

Consequently, a second feature emphasized during the psychosocial medical rotation is self-awareness. Residents are encouraged to examine their own stories, to become more cognizant of unconscious personal issues (e.g., fears of losing control of the interview, dealing with patient emotions or death) that might impede both the interview process and their relationships with patients. Finally, the third feature of the rotation is a series of lectures and rounds with a faculty psychiatrist who teaches the residents to recognize and manage depression, anxiety, and other psychiatric problems that commonly occur among patients who seek help from primary physicians.

In the short term, evaluation from residents completing the curriculum has been generally positive, and the efficacy of the curriculum has been demonstrated through research (Smith, et al., 1991, Smith, Lyles et al., 1995, Smith, Mettler et al. 1995). Nevertheless, in addition to their favorable comments, some residents have also indicated that time could have been better spent on purely medical rotations. In essence, the immediate concern of many residents centers on patients' biomedical issues, not interviews--the contribution of the patient-centered interview and psychosocial medicine to optimal treatment is sometimes discounted.

No research has been conducted to determine the perceived value of the psychosocial medicine rotation to residents either later in their

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residency or once they are in practice; nor has there been research to explore how that value manifests itself in communication practices. Specifically, there have not been explorations of whether particular patient-centered interviewing skills become more important over time. Likewise, the long-term impact of self-awareness issues on communication skills and the development of the doctor-patient relationship needs to be examined. The purpose of this research is to explore these communication issues with physicians who were trained in the psychosocial rothation during their first year of residency and are now in their third year of residency, in fellowships, or in actual practice.

Before the meaning of this rotation to residents can be fully understood, however, it is essential to look at the rotation in the context of medical education and the social influences that determine the philosophical emphasis of our medical institutions. The chapter that immediately follows provides an overview of that context. In it, the mechanisms of the medical education experience are explored--idealism and altruism juxtaposed with demands to master overwhelming amounts of subject matter and to acquire an impenetrable professional demeanor. Second, the development of interest in the communication and relationship-building components of psychosocial medicine and their infusion into medical education are discussed. Next, the substance of MSU's psychosocial teaching curriculum is outlined and its relationship to medical education and practice is suggested. The chapter ends with a brief summary that includes general research questions and an argument for qualitative methods using grounded theory methodology.

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The third chapter contains the research methods employed to study the long-term effects of the psychosocial rotation. The sample is described and data collection instruments and procedures are outlined. In addition, a detailed summary of grounded theory coding methods is included. In the final two chapters, the results of the qualitative analyses are described, summarized, and the implications of the findings discussed.

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CHAPTER TWO: THE CONTEXT OF THE PSYCHOSOCIAL ROTATION

> *"The students of medicine, it turns out, see their world in a moving perspective. How to climb the distant mountain may be the question in the backs of their heads; how to make their way across the swamp they are foundering in now and over the steep hill just ahead engages their immediate attention."* -- Becker, Geer, Hughes, & Stauss, 1961; p.5

The process of medical education has changed little in the last thirty-five years. Researchers have consistently noted the clear idealism with which students first view the practice of medicine followed by its gradual fading as the pragmatic realities of becoming a doctor unfold before them (Becker, Geer, Hughes, and Strauss, 1961; Haas & Shafir 1984; Konner, 1987; Lief & Fox, 1963; Marion, 1991; Miller, 1992). Achieving the goal of practicing medicine means students must master a tremendous amount of information and become capable of making objective decisions regarding the care of patients. They are often concerned that even more knowledge is necessary than will be covered in their medical education (Becker et al., 1961; Finkelstein, 1986; Marion, 1989). That apprehension is the beginning of socialization into the medical profession.

Socialization in Medical Education

Socialization into a profession is generally defined as accumulated knowledge, communicated explicitly and implicitly, formally and informally, that is necessary to assume a professional role (e.g. see Jablin & Krone, 1987). Included in this social knowledge are professional values, abilities, and expected behaviors essential to competent performance. The medical

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school curriculum, and the accompanying norms surrounding its components, are a major source of socializing communication for the aspiring physician.

The first two years of medical school are spent primarily in the classroom. Hard sciences including anatomy, physiology, biochemistry, and neurophysiology are the focus of year one, and for the most part, students spend their hours in large lecture classes and laboratories. Clinical experience with patients is introduced in the second year, but it is not a dominant activity until the third and fourth years.

Becker et al. (1961) in their early landmark work, Boys in White, reported that the most pressing problem for students during the first year is overload. This problem is in no way mitigated by the faculty who typically emphasize to their classes to "'Start work immediately because there will be no time to catch up'" and that it is the students' "'... responsibility to learn as much as you have capacity for in the time that you have....'" (Becker et al., p. 81).

These themes are echoed in more current chronicles of medical education as well. For example, in describing their experiences in medical school and internship, Konner (1987) and Marion (1991) both indicated the incredible pressure on students to learn "everything". Studying three hours an evening is considered slacking off. Indeed, the norms regarding studying are so strong that even occasional "time off is redefined as necessary recreation in order to study well" (Becker et al., 1961; p. 95).

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The Medical School Curriculum

It is not studying hard that makes medical school unique; it is the material that is studied. Medical students are, after all, in school to learn to treat the human body, and their first institutionalized encounter with one is in the anatomy laboratory.

Suppression of feeling. It is not surprising that the anatomy laboratory experience has received a great deal of attention in the medical education literature (e.g., Finkelstein, 1986; Hafferty, 1988). Anatomy lab typically begins in the first semester of the first year and contains a crucial combination of elements that initiates socialization into the medical profession. First, voluminous information is covered--an estimated 7,500 new scientific terms must be learned (Finkelstein, 1986); second, there is direct contact with the human body--dissection of a human cadaver; and third, there is the development of detachment that makes the second element possible (Lief & Fox, 1963).

In his four-year study of medical students in the anatomy lab, Finkelstein (1986) documented what he calls the explicit course (the physical work of dissection and the mental work of identfying and committing to memory detailed parts of the human anatomy), and the implicit course: "... if one includes the unspoken task of adapting to these vivid reminders of death and aging, it becomes a far more complex course to conceive of--for in parallel with these concrete elements, students must quietly learn to handle their responses to the dead body and what it represents to them" (p.26).

Learning to handle their responses in the lab generally means adopting powerful norms of suppressing emotion and acquiring scientific

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objectivity (Finkelstein, 1986; Hafferty, 1988; Lief & Fox, 1963). Hafferty (1988) asserted that much of the emotional socialization of the anatomy lab is accomplished through relating cadaver stories that are defined as "narratives describing 'jokes' played by medical students on unsuspecting and emotionally vulnerable victims" (Hafferty, 1988; p. 344).

Of import here is that these stories appear to be universal. Hafferty's research spanned fourteen years and the rules conveyed in the stories remained constant. They mandated that "information about the affective dimensions of medical work be hidden not only from lay outsiders, but also from peers and even from oneself" (p.353).

Suppression of feeling is corroborated by other researchers as well (Becker, 1961; Coombs & Powers, 1975: Finkelstein, 1986; Haas & Shaffir, 1984; Konner, 1987; Lief & Fox, 1963; Marion, 1991). Finkelstein's work in 1986 elucidates Becker et al.'s (1961) earlier observation that that no students spoke of cadaver work as traumatic. As Finkelstein (1986) points out, for students to do so would be unprofessional:

> The most encompassing norm within the anatomy lab is the complex requirement for professional conduct. Students are expected to "act like a doctor," even on the third day of medical school. They are expected to place their acquisition of knowledge above all other priorities, to treat the cadaver, their first patient, with respect, and to deal with any emotional responses they may have to the situation in private. Displays of true anxiety or sorrow are tacitly discouraged, but shows of frustration or disappointment

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Scientific language. Ironically, the scientific terms that are a source of academic pressure are also a source of emotional relief. Scientific language is the language of the medical faculty--using it helps students to identify with their mentors (Lief & Fox, 1963). In addition, it functions to help students control feelings and to protect themselves from emotion-laden experiences not only in the anatomy lab, but also later, when dealing with patients, patients' families, death, and their own emotions (Finkelstein, 1986; Lief & Fox 1963). Lief and Fox (1963) explained that while scientific language is essential in order to express concepts precisely, it tends "to dull perceptions and conventionalize responses" (p. 30)--an effect, they posited, that is often welcomed by medical students when they are feeling anxious.

Recognition of the consequences of error. Although not unique to the medical profession, certainly the recognition of the consequences of error permeates the medical student's psyche and dictates priorities. "Not knowing enough" could result in a patient's death. It is little wonder that hard work, scientific understanding of disease, clinical excellence, and emotional control are the essence of medical professionalism. These values learned in the first year are embraced in the following three years and continue to be enhanced during internship and residency.

Becker et al. (1961) noted that students "absorb medical culture in a selective fashion to help meet the problems posed by their school environment" (p.192). In the beginning, students try to learn everything; later, recognizing that goal is unachievable, they work hard to determine what is most important to learn. In the clinical years, Becker asserted that

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"medical responsibility and clinical experience" become the "collective perspective," the guiding prinicples of where to invest effort. Becker observed that medical responsiblity means "responsibility for the patient's well-being..." (primarily the patient's physical status); and experience means actually "dealing with patients and disease" (p.223).

These principles lead students to judge the worth of lectures, conferences, teachers, and rotations on the degree to which their clinical skills and biomedical knowledge have been enhanced (Becker, 1961): "No words spoken to medical students carry the sort of power conveyed by those who speak from clinical experience" (Konner, 1987; p.21).

Clearly, based on Konner (1987) and Marion's (1991) narratives describing the medical education experience, what Becker observed decades ago is still operative today. The basic elements necessary to become a competent physician remain the same. With vast technological and pharmacological advances to comprehend and integrate into medical treatment in addition to mastering human physiology, it is not only understandable, but necessary that those entering the medical profession give "medical responsiblity" and "experience" high priority.

Working toward detached concern. It is also essential that some objectivity overtake the subjective and emotional experiences of dealing with human flesh, suffering, disease, and death. Indeed, Lief and Fox (1963) called this objectivity "detached concern" and gave a compassionate account of how this detachment is initiated in the early phases of medical school. They contend that medical education strives to create an empathic physician who is "sufficiently detached or objective in his [sic] attitude toward the patient to exercise sound judgment and keep his equanimity, yet

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he also has enough concern for the patient to give him sensitive, understanding care" (p.12).

Miller and her colleagues (Miller, Stiff, & Ellis, 1988; Miller, Birkholt, Scott, & Stage, 1995) in their research on empathy and burnout in human service workers, elucidated the mechanism by which detached concern may function to protect physicians from burnout. Their work distinguishes between two types of empathy: a) emotional contagion in which a person actually feels with the emotions of another; e.g., literally crying with a bereaved person, and b) empathic concern in which a person feels for another; e.g., expressing concern and sympathy without actually experiencing the same emotion as the bereaved. With human service workers, empathic concern had a large positive effect on communicative responsiveness which, in turn, had a negative effect on burnout. In contrast, emotional contagion had a negative effect on communicative responsiveness and a subsequent positive effect on burnout.

These findings are consistent with Lief and Fox's (1963) notion of detached concern and suggest that appropriate suppression of emotion in the socialization of medical students does not preclude producing empathic physicians. Indeed, the findings indicate that the expression of empathy (empathic concern converted to communicative responsiveness) provides protection from the burnout that frequently occurs in the helping professsions. Nevertheless, the necessary, well-intentioned, aspects of the socialization process sometimes produce less than desirable results.

The Negative Side of the Socialization Process

The goal of detached concern is seldom reached without faltering. Lief and Fox (1963) remarked that sometimes an unhealthy process of over-

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detachment begins during medical school and persists into medical practice leading physicians "to perceive and treat patients mechanistically" (p.21). Certainly, for the majority, persistent pathologic over-detachment does not occur, but a loss of idealism and tendency to objectify patients appears to be a common by-product of medical education that starts with anatomy lab and continues through postgraduate training (Becker et al., 1961; Coombs & Powers, 1975; Haas & Shafir, 1984; Konner, 1987; Marion, 1989; Marion, 1991; Miller, 1992; Mizrahi, 1984).

Some researchers posit that objectifying patients is a natural, and almost unavoidable, outcome of "striving to demonstrate a developing and maturing competence in a short period of time" (Haas & Shafir, 1984; p. 74). Even in medical schools where psychosocial issues are emphasized, there is evidence that medical students focus on patients' biomedical symptoms, losing sight of patients as people. Indeed, Haas and Shafir (1984) observed in such a school that medical students tended to view patients as "materials to learn from" (p. 71) and psychosocial issues as "nebulous" (p.68).

Treating patients as objects, however, is far less benign than an over-zealous interest in biomedical symptoms suggests, and is an outcome of more than striving to master the practice of clinical medicine. In the clinical years of medical school and the postgraduate experience of internship and residency, factors of time and work load interact synergistically with pressures for clinical competence and professional demeanor to produce negative coping strategies induced by the objectifying process (see Haas & Shafir, 1984; Konner, 1987; Marion, 1991).

The Process of Objectifying Patients in the Clinical and Postgraduate Years

> *During medical school and residency, the authoritative--and lethal--script is often 'cope successfully, without let-up, without feeling, with no signs of weakness and without asking for help.' Not surprisingly, an outcome is that students forge emotional barriers between themselves and their patients and become increasingly inaccessible to genuine encounter."*
> -- Puckett, Graham, Pounds, & Nash, 1989; p.231

Lack of time is a recurrent theme in the medical education literature. It is an explanatory variable for the priorities established both in the classroom and in the clinical setting. As medical education progresses into the third and fourth years of medical school and beyond (internship and residency), time constraints become more pronounced and the opportunity for negative effects of the socialization experience increase (Becker, 1961; Haas & Shafir, 1984; Konner, 1987; Lief & Fox, 1963; Marion, 1991; Mizrahi, 1984; Puckett et al., 1989).

The socialization process in the clinical setting is a combination of what is experienced and what is observed. Harried third and fourth-year medical students often learn basic clinical skills in a hospital environment where interns and residents are also receiving training (Konner, 1987; Marion, 1991). At a minimum, residents' attitudes and behaviors are observed by medical students. Not infrequently, along with the teaching faculty, interns and residents supervise and instruct medical students in some of the basic skills--in essence, while still in the process of being socialized themselves, they become mentors to medical students (Konner, 1987; Marion, 1991).

The difficulty with this fast move into the mentor position is that the residents are not always the best role models. They have learned the scientific language, the supression of emotion, and much of the voluminous

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subject material, but have also acquired additional burdens at this stage of their medical education: "They are outrageously overworked, sleep-deprived, over-burdened with responsibility, bewildered by a barage of ever-changing facts, and oppressed by the medical hierarchy, of which they are on the lowest rung" (Konner, 1987; p.363). Thus, their mentoring abilities are severely compromised.

Strategies for Coping

The combination of sleep deprivatrion and significant increases in patient load can affect communication skills in a variety of ways. Robert Marion (1989) suggested that lack of sleep can result in residents' loss of social skills to the point that communication with patients and their families actually becomes torture. The loss of social skills is corroborated by Plotnikoff (1992) who asserted that, "...today's hospital-based training constricts any resident's ability to see, much less develop, meaningful physician-patient relationships" (p.1197). Furthermore, the continual pressure to assume medical responsibility and gain appropriate experience, coupled with increased patient volume, reinforces and exaggerates patterns initiated in medical school--more emphasis on biomedical information, fewer expressions of polite conversation.

For example, Konner (1987), in an autobiographical account of his third year of medical school, wrote that among interns and residents:

> ...humane acts not directly affecting *'care'--a word meaning neither more nor less than medical and surgical intervention for the purpose of favorably altering the course of an illness* [italics added]--are in short supply in the hospital world; that patient's mental status is only marginally relevant to

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> the effort at helpful verbal or nonverbal communication; and that far from being embarrassed by brusqueness, residents are far more likely to be embarassed by (and not consider quite professional) acts and gestures that are other than completely instrumental. (p.26)

This observation is supported by other researchers. As a participant-observer, Mizrahi (1984) intervewed eighty-three interns and residents at various stages in their postgraduate training. He noted that time constraints are exacerbated in residency: "The current system of graduate medical education subjects interns and residents to long hours of extremely demanding work....This combined with increasing technical development of medicine, requires that interns and residents develop ways of lightening their major burden--their patient load" (p.164).

Mizrahi documents several strategies used to cope with enormous case loads and their concomitant record-keeping demands: "1) avoiding patients and their families; 2) narrowing the focus of interaction to strictly 'medical' concerns; and 3) treating patients as non-persons--even in their presence" (p. 158). These coping mechanisms manifest themselves in specific communication practices such as not speaking directly to hospital patients while conducting exams (e.g., speaking about them to colleagues in the third person) and dominating interactions by using superior medical knowledge and status to control topic selection (Mizrahi, 1984).

Even with the best intentions, it seems these negative coping techniques are very likely to be used eventually. Konner (1987), who initially was amazed by residents' work habits, stated that as time went by he appreciated their time saving strategies and recognized that he would

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soon be doing the same. Konner also corroborated Mizrahi's findings: "They (the residents) focused more narrowly on present illness, showed less concern for the patient's, or certainly, the family's general health; paid less attention to behavioral and social factors in the patient's illness; were more abrupt and brusque and less responsive to the patient as a human being" (p.33).

Time constraints, work load, and pursuit of scientific competence are not the only contributors to the objectifying process. The norm and/or need to suppress emotion is also a contributor. Nothing is more effective at controlling emotions than creating distance by seeing the patient as a set of symptoms. To take into account the psychosocial environment of the patient is to see the patient as a whole person--issues of human pain, death, and sexuality become more than a biomedical problem. If the patient is a whole person, these issues must be discussed in language that transcends biomedical jargon; and if the protection of scientific language diminishes, emotions will rise.

Changes in the Postgraduate Environment

In the last ten years, there have been improvements in internship and residency programs that have helped to humanize the experience and perhaps mitigate the some of the negative socialization process. One important catalyst for these changes was the tragic death of Libby Zion in 1984. The circumstances surrounding her death involved over-tired, unsupervised residents who were in charge of her care (Litwin, 1991; see Asch & Parker, 1988 for a full discussion of the case).

Following Libby Zion's death, new recommendations concerning the work conditions and supervision of residents were published (American

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College of Physicians [ACP], 1989). As a result, sleep deprivation has been addressed by reducing on-call assignments to a maximum of twice a week instead of every other night; patient load has been decreased at most teaching hospitals; and encounters of humiliating verbal abuse from superiors, seldom addressed in the medical education literature, are far less common (Litwin, 1991; R.C. Smith, personal communication, January 26, 1993).

In spite of these positive changes, however, other factors have emerged that continue to keep residency an environment conducive to objectifying patients. First, in our litigious society (Annadale, 1989; Valente, Antlitz, Boyd, & Troisi, 1988), residents have the added burden of learning and considering the legal implications of their medical decisions. The degree to which residents feel concern about lawsuits can diminish trust and contribute to their distancing themselves from patients (Valente, Antlitz, Boyd, & Troisi, 1988).

Second, residents are under tremendous pressure to know more technology and use it efficiently. For example, even though hospital patient assignments have decreased, to qualify for admission, patients are generally sicker when they are admitted than in times past (Plotnikoff, 1992). This not only means more physical work per patient, but also the increased stress of dealing with more severe illness. In addition, current health care cost considerations (e.g., the advent of diagnostic related groups [DRGs]) demand that residents move patients through the hospital quickly. Patients are seldom admitted for routine work-ups, and if they are, tests are completed in two to three days. The result for the resident is as much, if not more, paperwork than ever to be completed in a shorter period of time

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It is also increasingly common for many of these hospitalized patients to have no primary doctor, no health insurance, yet have monumental, and often unresolvable, psychosocial and biomedical problems. At one time patients with this profile were typically seen only at large, urban hospitals. Due to the nation's economic problems of the last decade, the profile has become more widespread, and patients with these problems appear in ever-increasing numbers in smaller city and rural hospitals (R.C. Smith, personal communication, January 26, 1993). Clearly, the stress of dealing with patients with difficult problems can be overwhelming, and limiting oneself to biomedical issues can be viewed as an understandable coping mechanism.

This discussion of the socialization process and contributing factors in the hospital setting is not intended to imply that all residents use only negative coping strategies or that all residents necessarily objectify patients. Rather, it argues that the intrinsic elements of medical education have remained relatively unchanged over the last three decades; that the improvements in residency education have been replaced with new pressures; and that the cumulative experience of medical school and post-graduate medical education continues to temper, in varying degress, the idealism and altruism of entering students.

Moreover, the summary describes the context in which first-year interns and residents experience the mandatory psychosocial medicine rotation at Michigan State University. Although the previous discussion provides some evidence that such a rotation is needed to reinstate a balance in residents' education, to help them to consider the whole patient, it should

be equally clear that the receptivity to the rotation is compromised by the physical and clinical demands of residency. At best, one would expect residents to greet the subject matter with ambivalence. On one hand, the humaneness of psychosocial medicine is integral to their identity as physicians; it represents the altruism and idealism that may have helped to kindle their interest in medicine. On the other hand, there are a multitude of factors (e.g., time pressures, quest for scientific information) that pull them toward operating strictly under the guise of the biomedical model.

Given the various socialization elements at play, the process by which psychosocial medicine became introduced into medical schools and postgraduate education merits discussion. The following section explores the societal context that not only fostered the socialization process described above, but also encouraged incorporation of interview training and the biopsychosocial model into medical education.

Introducing Psychosocial Medicine into Medical Education

In the past thirty years, three predominant factors merged to create a place for psychosocial medicine in medical education: (a) the evolution of medical care from a curative emphasis to a preventive emphasis; (b) the influence of psychiatry on general medical practice; and (c) the renewed understanding of and interest in the therapeutic value of doctor-patient communication.

Changes in Medical Care

During the first half of the twentieth century, medical science made tremendous progress in stemming infant mortality and increasing life expectancy. The discovery of penicillin and other antibiotics, in addition to vaccines for poliomyelitis, diphtheria, and typhoid fever, marked a transition

in medical research and practice from care and cures of acute infectious illnesses to research and practice focusing on chronic diseases (Rutstein, 1967); e.g. diabetes, hypertension, heart disease, cancer treatment. Research became more complex; technology advanced; and scientific knowledge increased (Starr, 1982). Between 1965 and the present alone, diagnostic tools such as cardiac catherization, computerized axial tomography (CAT scans), and magnetic resonance imaging (MRI) were developed. Surgical interventions such as heart by-pass surgery, total hip, knee, and shoulder replacements, and innumerable transplant procedures accompanied the diagnostic advances.

Along with this progress came a pronounced trend toward specialization and a decrease in the number of primary care physicians (Rutstein, 1967) as well as a decline in the latter's status. For example, by 1967 a patient's admission to the hospital usually required a specialist's approval. Patients' interactions with a variety of specialists necessarily meant that their problems would seldom be examined in the context of the whole person; narrow focusing compromised the doctor-patient relationship (Starr, 1982).

Paradox in modern medicine. Interestingly, almost simultaneously with the proliferation of specialists and advanced medical and surgical techniques, a paradox in modern medicine became apparent: the quality of U.S. health (e.g.,infant mortality and life expectancy) was not improving proportionally to high per capita health care expenditures and expanded research programs. This paradox, noted by Rutstein in 1967, is still operative today (Tarlov, 1992).

Tarlov (1992) suggested three potential explanations for this

phenonmenon: (a) medical care intervenes late in the treatment of illness particularly for those who have limited access to the health care delivery system; (b) the benefits of current medical interventions cannot be measured by life expectancy and morbidity and mortality; and/or (c) health, and strategies to improve it, are related to societal circumstances. The latter refers, in part, to the shift in causes of illness and death from infectious organisms to risky behaviors such as diet and tobacco use.

Redefinition of health. Regardless of the explanations ascribed to it, the acknowledgement of this paradox has drawn attention to the need to reassess the health care delivery system in the United States, and has promoted the gradual adoption of new definitions of the meaning of health (Tarlov, 1992). One of the first reconceptions, proposed by the World Health Organization in 1947, shifted the definition of health from the absence of disease to a state of well-being that includes physical, mental, and social dimensions (Tarlov,1992).

Refinements of this definition are continually submitted for consideration. For example, Zook (1994) suggested the need to expand the biopsychosocial definition of health to include the notion of ontological health--acknowledgement of the authentic state of being of the individual in addition to physical, social, and emotional well-being. Although modifications to the definition will no doubt continue to be suggested and adopted, the departure of the meaning of health from the original disease-free description is undoubtedly permanent, and its impact important to note. Indeed, both patient-centered models of interviewing (Smith and Hoppe, 1991) and clinical medicine (Stewart et al., 1995) explicitly embrace the biopsychosocial definitions of health and implicitly adopt the ontological in

their discussions of what constitutes the "whole" patient.

Both the redefinition of health and interest in health care delivery reform have had tremendous implications for medical education. Knowledge of patients' physical, mental, and social dimensions requires both understanding patients as whole people and doctor-patient relationships that foster such understanding. Furthermore, health care delivery to all segments of the population, preventive medicine, and early identification and treatment of chronic illnesses imply continuity of patient care that is most logically provided by primary care physicians (Petersdorf, 1992).

As witnessed in the long struggle toward health care reform in this country, implications such as these generally take a slow and varied path toward impacting policy and even longer to actually effect change. Engel's (1977) call for a biopsychosocial model of medicine that incorporates psychological, behavioral, as well as physical components of illness; the 1983 American Board of Internal Medicine mandate that internal medicine residents demonstrate competency in humanistic and psychosocial skills; Feinstein's (1983) advocacy of obtaining quality information during medical encounters to improve the 'measurement' of the clinical and personal phenomena of patient care; and Tarlov's 1992 essay calling for medical education to include a foundation in the social, as well as natural, sciences, are examples that attest to the slowly evolving unity toward a broader medical education--both in medical school and in post graduate primary care residencies.

Resumed interest in primary care. Interest in primary care medicine was certain to increase as soon as it became clear that the decline in primary care physicians had created a "short supply." Indeed, family

practice was reinstated as a formal medical specialty in 1969, in part to help encourage a holistic approach to health care, and in part to "address the growing specialist-generalist imbalance within the health care system" (Burns, Scott, Burke, & Kessler, 1983; p.157).

Petersdorf (1992) noted that while "primary care's time has come" (p.377), a downward trend in U.S. medical graduates entering primary care continued. To some extent, this continuing trend was due to anticipation of low income. Gradually, incomes for primary care physicians have increased as the demand for them has grown (Jeffrey, 1994). The understanding of health as more than the absence of disease, and the treatment of chronic illnesses has helped nurture the proliferation of health maintenance organizations and managed-care health insurance plans--both require primary care physicians as gatekeepers for tests and referrals to specialists (Jeffrey, 1994).

More recently, the Clinton administration has stated the desire to have an equal ratio of primary care physicians to specialists (currently 70% of the nation's physicians are specialists); already a "growing portion of federal money, which funds the lion's share of medical education, has been earmarked for primary care" (Jeffrey, 1994, p.12A). As a further marker of the resurgence of primary care, the structure for medicare reimbursement procedures for primary care office visits was modified in 1992. Recognizing that the complexity of treatment may vary considerably, primary care physicians are now permitted to bill for longer patient interviews that presumably attend to psychosocial issues; concurrently, billing rates for specialists have decreased slightly.

Finally, the advent of managed care has bolstered not only

primary care, but also the biopsychosocial model. In managed care, fees are paid in advance and service is provided by specified physicians who are members of an insurance group. As with any insurance, sufficient numbers of enrollees are essential to financial soundness. However, in the managed care environment, patient satisfaction becomes more critical to success. Unlike traditional medical insurance, managed care insurers are tied directly to their physicians. Dissatisfied patients not only leave a physician, but also the insurer making competition for patients fierce and physicians' attention to patients' biopsychosocial needs more crucial.

It should come as no surprise that concomitant with the slowly evolving restoration of primary care and the reconceptualization of health that a renewed interest in the therapeutic effects of the doctor-patient relationship, and its core communicative component, the medical interview has grown. This discussion would be remiss, however, if it did not specifically acknowledge the role of psychiatry in the development of the medical interview as well as the concept of psychosocial medicine.

The Influence of Psychiatry on Medical Practice

The influence of psychiatry on general medical practice is evident in two areas. First, in the development of the medical interview itself; and second, in the treatment of medical patients.

The medical interview did not always have a prominent place in medical education. Stoeckle and Billings (1987) noted its prototype, the medical history, was often reflected as a brief note on an index card. Not infrequently, only one line was devoted to personal inquiry such as patient age, occupation, martial status, and number of children; the remainder was primarily an outline of the patient's current physical complaints. This

technique required no textbooks. Instead, it was taught by demonstration to medical students and residents. Although suggestions of types of useful questions to ask were sometimes embedded in diagnostic or clinical textbooks (see Bates, 1991), they generally focused on questions to ask in search of disease (Stoeckle & Billings, 1987). After all, as the label suggests, physicians were after the "history" of the symptoms. The introduction of "...process skills: how to ask questions and evoke responses, or how to listen, talk, and explain" (Stoeckle & Billings, 1987; p.121) and its name change from history to interview came by way of psychiatry.

As a direct result of successful collaboration with medical personnel during World War II in treating "battle fatigue" and "shell shock," psychiatrists were asked to join staffs of general hospitals beginning in the 1940s (Stoeckle & Billings, 1987). With them, the psychiatrists brought to the general hospitals a systematic way of teaching students to elicit information from patients: "In effect, the psychoanalytic questioning technique of free association was transferred to the medical inquiry" (Stoeckle & Billings, 1987; p. 122). Non-directive questioning allowed patients to disclose physical and psychological components of their illnesses; concepts such as "empathy" and "unconditional regard" were introduced (Stoeckle & Billings, 1987). By the late 1980s, interpersonal skills and behaviors were common in the curricula of the majority of U.S. medical schools. Moreover, teaching these skills changed in many medical schools from bedside observation alone to a more formal structure including classroom lectures (Kern et al., 1989; Stoeckle & Billings, 1987).

The influence of psychiatry is not limited to the techniques of the

medical interview alone. In the 1940s and 1950s, there was a general increase in understanding psychological and psychiatric concepts (Korsch, 1987). This understanding along with the actual presence of psychiatrists in general hospitals created an environment where psychiatrists could "demonstrate that psychological components were invariably present with physical disease and deserved attention" (Stoeckle & Billings, 1987, p.122).

Recognition of the psychological components of illness, coupled with health policy factors including the supported growth of health maintenance organizations, helped to foster the "movement of mental health into the mainstream of health services" (Pincus, Strain, Houpt, & Gise, 1983; p.3065). As evidenced in the medical literature, by the 1980s there was general acknowledgement of the prevalence of depression and other emotional and behavioral problems among primary care patients (Cohen-Cole, Boker, Bird, & Freeman, 1982; Meuleman & Caranasos, 1989; Novack, Goldberg, Rowland-Morin, Landau, & Wartman, 1989; Strain, Pincus, Houpt, Gise, & Taintor, 1985). It has been estimated that 54% of Americans suffering from some form of mental disorder are seen by primary care physicians, not psychiatrists (Burns, Scott, Burke, & Kessler, 1983). Furthermore, an additional 15 to 50% of all patients seeing physicians for physical complaints are thought to have some degree of emotional or cognitive disorder (Strain et al., 1985).

As the acceptance of the relationship between mental health and "the development, onset, course, and treatment of physical disorders" (Strain et al., 1985; p. 95) grew, a major concern of the medical community became what and how to teach primary care physicians to address these issues (Balint, 1964; Cohen-Cole et al., 1982; Kern et al., 1989; Novack et

al., 1989; Pincus et al. 1983; Smith et al., 1991; Smith, Marshall, & Cohen-Cole, 1994; Strain et al., 1985; Williamson, et al., 1992). Interest grew not only in appropriate treatment and management of psychiatric disorders and emotional problems in general practice, but also the in the development of of positive and therapeutic doctor-patient relationships (Strain et al., 1985).

The Doctor-Patient Relationship

As is true in any relationship, the heart of the doctor-patient relationship is communication:

> ...successful relationships with patients require providers to communicate clearly and effectively. Practitioners first must know the elements and impact of effective communication. Necessary skills include the ability to impart information, listen openly and nonjudgmentally, learn, facilitate the learning of others, and encourage the expression of--and accept--the patient's emotions (Tresolini, 1994; p.30).

Although the centrality of communication and the therapeutic nature of the doctor-patient relationship are not new concepts, the "actual dynamics of the therapeutic dialog" (Roter, Hall, & Katz 1988; p.99) have only been consistently observed for the last twenty years. Research and interest concerning the dynamics and communication patterns between doctor and patient doubled between 1983 and 1988 alone (Roter et al., 1988).

This burgeoning field of research emanates from a variety of disciplines (e.g., medicine, sociology, psychology, communication) and has raised concern for some. Most notably, Burgoon (1994) warned communication scholars about complacently accepting the notion that "nice" communication is the best communication. In the area of health

communication, he voiced concern that patient noncompliance, for example, is viewed often to be solely the failure of the physician to give enough information or to be sufficiently interpersonally sensitive. According to Burgoon, this type of ideology leads to the pursuit of certain lines of research and to the exclusion of others. Using his own experience as an example, he noted that his research suggesting that noncomplying patients respond better to verbally aggressive physicians (Burgoon, et al., 1990) is less apt to prompt additional studies than work suggesting that either empathy or warmth is associated with patient satisfaction and compliance (Burgoon, 1994).

Although this caveat is well worth noting, it does not diminish the large body of evidence (see following discussion) that suggests that physicians do, indeed, need to talk "nicer" to patients in very specific ways; e.g., eliciting patients' complaints, allowing patients to express concerns, refraining from interrupting the patient (Stewart, 1995). Medical educators from a variety of disciplines (medicine, psychology, sociology, public health, communication) who teach communication skills in medical schools and residency programs, have taken their cues from a variety of research studies (see Smith, 1995 and Stewart et al., 1995 as representative examples). The discussion that follows presents an overview of the issues--some quite pragmatic--that have helped to sustain interest in the development of healthy doctor-patient relationships and the requisite communication skills that foster them.

Communication and liability. There is a lengthy history of research associating poor communication with malpractice suits. More than thirty years ago, Blum (1960) reported that patients' malpractice suits and

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failure to pay doctors' bills were related to poor doctor-patient communication. Later, Valente, Antlitz, Boyd, and Troisi (1988) corroborated the link between poor communication and malpractice litigation noting specifically that lack of physician empathy, lack of information, and perceived lack of physician remorse for negative outcomes often led to medical liability claims. As recently as 1992, it was estimated that seventy-five percent of malpractice suits lost by physicians reflected poor communication (Nazario, 1992).

Communication and health. Perceived lack of physician empathy, however, appears to lead to more than litigation--it can lead to poor health (see Thompson, 1994; Stewart et al., 1995 for reviews). Indeed, there is a body of literature that relates patients' dissatisfaction with physicians' communication skills (e.g., lack of warmth, poor explanations, failure to address patient concerns) to noncompliance with medical treatment (Blum, 1985; Hulka et al., 1976; Korsch et al., 1968; Swain, 1978). Furthermore, among patients with chronic diseases, reduced physician information-giving and low levels of patient control in the doctor-patient dialogue have been associated directly with poorer health outcomes (Kaplan, Greenfield, & Ware, 1989).

Specifically, Kaplan, Greenfield, and Ware (1989) found that patients who have more control during a medical appointment (defined by asking questions and interrupting the physician) have greater improvements in blood pressure and blood glucose control as well as improvements in functional limitations; when doctors have more control in an interaction, the opposite occurs. In their study, the patients were trained to effectively elicit more information from their doctors. These researchers posit that the

physician's act of giving information at the patient's request:

> ...in the form of instruction, education, or explanation, may contribute to patients' understanding, sense of well-being, and/or confidence regarding the management of their disease. Doctors may in fact influence the outcomes of patients with chronic illness, not only by competent medical care, but also by shaping how patients feel about disease, their sense of commitment to the treatment process, and their ability to control or contain its impact on their lives. (p.244)

Although in this research patients, not physicians, received communication training, the benefits derived from relationships in which control of the medical interview is shared and patient information needs are met, appear to hold regardless of whether they result from patient initiatives or physician facilitation. Furthermore, this work clearly illustrates that communication skills relevant to the doctor-patient relationship can be taught.

Kaplan et al.'s study is also consistent with Blum's (1985) description of physician communication practices that can induce patients' non-cooperation, acting-out (i.e., being late or breaking appointments), and/or seeking other, sometimes less experienced or less qualified, medical providers. According to Blum, included among those practices are (a) the physician's failure to give adequate information and explanation of symptoms and disorders and (b) the use of technical jargon to exert power, control, and to reduce physician anxiety by creating emotional distance between patient and physician.

Understanding the communicative behaviors that contribute to a troubled doctor-patient dyad is helpful in determining ways to develop a more positive relationship. Valente et al. (1986) suggested improving communication by using several techniques including open-ended questions, providing patients with positive feedback and reassurance, and summarizing information.

More recently, in their book on patient-centered medicine, Stewart et al. (1995) advocated "four key dimensions to be effective: clear information; questions by patients; willingness to share (discuss) decisions; and agreement between patient and doctor about the problem and the plan" (p.190). The efficacy of these dimensions has been corroborated by research indicating that interventions to enhance what Stewart et al. refer to as "exploring the illness experience" (i.e., the interviewing portion of a visit) and "finding common ground" (i.e., the treatment/management portion of a visit) have positive outcomes for patients (Stewart, 1995).

Numerous other medical educators and researchers have advocated education in the use of these and other communication techniques that help to develop healthy, productive doctor-patient relationships and/or have positive associations with patient compliance and health outcomes (e.g., Beckman & Frankel, 1984; Engel, 1980; Hall, Kaplan, Greenfield, & Ware 1989; Marshall, 1993; Roter, 1989; Roter, & Rand 1981; Smith & Hoppe, 1991; Stewart et al, 1995). These techniques and skills have become the core components of recommended psychosocial medicine curricula discussed in a following section. Inherent in these recommendations is the underlying belief that a therapeutic doctor-patient relationship begins with a "shared understanding of the meaning of illness"

which "requires the healer to respond to the experience of the patient" (Tresolini, 1994; p.22).

Recognition of the contribution of communication skills to the therapeutic value of the doctor-patient relationship converged on medical education along with: a) the influence of psychiatry on the medical interview; b) acknowledgement of the prevalence of psychosocial problems among the primary care patient population; and c) the change in medical practice from curative to preventive. The confluence of these factors culminated in the incorporation of some form of psychosocial instruction into undergraduate medical curricula. The substance of that curricula, however, varies greatly from medical school to medical school. Even greater variation in psychosocial curricula occurs among internal medicine residency programs where fewer than half of all residency programs offer psychosocial medicine education, and many that do have only abbrievated programs (Kern et al., 1989; Merkel, Margolis, & Smith, 1990).

Nonetheless, from the core of experienced psychosocial educators and researchers, a consensus has developed of what should be taught and how to teach it (Kern et al., 1989; Smith, Marshall & Cohen-Cole, 1994; Stewart, et al., 1995). The following section contains the key elements proposed by experts in the field of psychosocial medicine.

Teaching Psychosocial Medicine

The numerous elements generally recommended for inclusion in a psychosocial medicine curriculum can be subsumed under three major categories: (a) interviewing skills, (b) doctor-patient relationship skills, and (c) management of psychiatric problems in primary care (Burns et al., 1983; Cohen-Cole et al., 1982; Kern et al.,1989; Lipkin, Quill, & Napodano,

1984, Novack et al., 1989; Smith & Hoppe, 1991; Smith et al., 1991; Smith, Marshall, & Cohen-Cole, 1994; Stewart & Roter, 1989; Stewart et al., 1995; Willamson et al., 1992;).

Interviewing Skills

The biopsychosocial medical model (Engel, 1977; 1980) provides the philosophical underpinning for interviewing skills advocated by researchers and educators in both psychosocial medicine and doctor-patient communication. Consistent with the redefinition of health discussed earlier, the biopsychosocial perspective is a systems model in which patients' biological health is unsevered from psychological and sociological well-being. The belief that "... understanding the patients' subjective experience of their illness is a key to comprehensive assessment and management" (Stewart & Roter, 1989; p. 253) requires competency in interviewing techniques that elict that information as well as relationship-building skills that nurture confidence and mutual understanding.

Educators concur that patients' psychosocial data should be explored before initiating biomedical data gathering (i.e., symptoms and past medical treatment). This approach is aptly labeled patient-centered interviewing (Lipkin, 1990; Marshall, 1993; Smith & Hoppe, 1991; Stewart & Roter, 1989; Stewart et al., 1995) because it refers to actions on the physician's part that acknowledge and meet the patient's needs to speak, to express problems, concerns, and emotions, to obtain information, and to help determine the agenda for the medical appointment. It is this patient-centered approach, recently expanded and described by Stewart et al. (1995) as a clinical medical model, that allows the meaning of illness to be explored and mutually understood.

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By learning specific skills such as when and how to use open-ended questions (e.g, "How are things going?"), facilitative comments (e.g., "Tell me more about that."), and silence to elicit patient talk, physicians are more likely to gather accurate and reliable information about the patient (Smith & Hoppe, 1991; Marshall, 1993). Moreover, the patient has an opportunity to present the context of his/her health and the physician the opportunity to understand the patient as a whole person, to make a more accurate diagnosis, and to suggest treatment options tailored to the patient's needs.

Additional skills advocated for inclusion in the interviewing portion of psychosocial curricula are emotion-handling skills (Cohen-Cole, 1991; Lipkin, 1990; Marshall, 1993; Smith & Hoppe, 1991; Stewart et al., 1995). These skills, in conjunction with numerous facilitative techniques, help to elicit and support emotions expressed by patients. Residents learn what to say to acknowledge hearing the emotion and how to demonstrate support and understanding. In essence, they are learning to convert empathic concern into communicative responsiveness (see Miller et al., 1995). Emotion-handling skills are crucial not only because a patient's feelings are a key component to understanding the psychological aspects of the patient's complete story, but also because the physician then has an opportunity to make the patient feel better, and in doing so not only enhance the doctor-patient relationship (Smith & Hoppe, 1991), but also, as Miller et al.'s (1995) research suggested, potentially boost his/her own sense of personal accomplishment.

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Building the Doctor-Patient Relationship

Developing good emotion-handling technique is only one element in building rapport with patients. Equally important are two concepts that have emerged in the medical education literature as linchpins of a healthy doctor-patient relationship: (a) development of physician self-awareness and (b) recognition of patients as partners.

Self-awareness. As Stewart and Roter (1989) pointed out, expertise in communicating requires more than merely having knowledge or rotely performing skills--it involves " a set of attitudes..., life skills, and experience..." (p.253). Indeed, attitudes are crucial. Smith (1986) noted that once residents learn basic interviewing skills, the persistence of poor interviewing performance is often due to unrecognized feelings about aspects of the physician-patient relationship. Physicians' personal attitudes and feelings about pain, drugs, obesity, noncompliance, poverty, and death and dying influence not only how they talk to patients about those issues, but also if they talk to patients about them (Korsch, 1989; Smith, 1986). Until such feelings are acknowledged, addressed, and attitudes appropriately adapted, both the interview performance and the relationship suffer.

Personal attitudes and feelings manifest themselves in a variety of ways. For example, many physicians find dealing with the anger, fears, and frustrations that surround patients' illnesses more difficult than treating biological symptoms. As a result, when patients express emotion, physicans may unconsciously avoid feelings by interrupting and/or shifting topics; others may preclude emotional expressions by aggressively controlling the interview from the outset (Smith, 1984). Reasons for avoidance are deep seated and may entail fears of causing the patient harm

(e.g., that talking about death or emotions will upset the patient) or of losing control of the interview and/or of their own emotions (Smith, 1984; 1986).

Clearly, such actions can restrict the growth of the doctor-patient relationship--not only by denying patients an opportunity to communicate what is important to them, but also by denying physicians the opportunity to offer comfort and support. Thus, most scholars agree that psychosocial curricula need to include efforts to help residents recognize and understand the variety of behaviors, feelings, and attitudes that can become barriers to the development of sound doctor-patient relationships (Kern et al., 1989; Korsch, 1989; Smith, 1984; 1986; Smith & Zimmny, 1988; Stewart & Roter, 1989). Furthermore, as Kern et al. (1989) pointed out, self-awareness training potentially provides multiple benefits--contributing to "... personal growth, continued self-directed learning, improved understanding of patients, effective management of doctor-patient relationships, and professional satisfaction" (p. 422).

Self-awareness is not attained in one four-week session. To the contrary, it accumulates and develops over time only with a great deal of work. The inclusion of self-awareness training in psychosocial medicine curricula should be viewed as a beginning of process. As Stewart, Brown, & McWhinney (1995) noted:

> The development of self-awareness requires that doctors know their strengths and weaknesses. What potential blindspots or emotional triggers elicit a negative response to certain patients? As Longhurst (1989) noted, self-awareness means confronting the emotional baggage emanating from our families of origin and conflicts in current relationships. Self-awareness and

> self-knowledge also have positive value in that they promote and nurture the qualities of empathy, sensitivity, honesty, and caring in the physician. Because acquiring self-knowledge is often a painful process, this form of knowledge is the most difficult of all to acquire. It is perhaps best seen as a lifelong journey: a process that is never complete. (p.96)

Just as physicians need self-awareness training to understand the role of their own personalities in creating barriers in doctor-patient relationships, they also need to understand their patients' personalities. Teaching physicians to identify, understand, and respond appropriately to patients' predominant personality features is the necessary counterpart of self-awareness training.

Although all people are a composite of different personality dimensions--(e.g., a blend of the compulsive, dependent, histrionic, etc.) certain characteristics may be more prominent than others and may become exaggerated under certain conditions. The dominant personality dimension may provide clues to the meaning of illness for a particular patient (Kahana & Bibring, 1964). If physicians are cognizant of basic needs associated with various personality types, they have an additional tool with which to build rapport, remove barriers, and/or successfully manage difficult encounters.

For example, patients with an underlying dependent personality structure generally need extra personal attention. Kahana and Bibring (1964) suggested that these patients are often more responsive if the physician is able to satisfy that need by encouraging them to call the office if they have any questions or by scheduling additional visits to reassure

them that medical needs will be met. Gradually, contact can be reduced as rapport develops.

Patients as partners. Although personality issues are necessarily individual, the issue of unrecognized controlling behaviors on the part of physicians is almost universal (see Stewart, Brown, & McWhinney, 1995 for a discussion of this issue). Physician behaviors that attempt to exert control include dominating the interview in pursuit of biomedical data, appearing rushed so that patients limit their discussion to symptoms, interrupting patients, shifting topics, and ordering treatments without patient input. Within the context of psychosocial medical education, recognizing these controlling behaviors (and the personal motivations behind them) and reliquishing some control is a second key element to building more egalitarian working relationships with patients.

Even though the concept of patients as partners has existed in the literature for the past two decades, its actual adoption into medical practice remains a slowly evolving process. Partnership origins are related to the legal rulings of the early 1970s surrounding the issue of informed consent and to the development of the self-help movement (Roter 1977). According to Roter, the informed consent rulings "established the affirmative duty of the physician to provide advice and adequate information...to a patient in order to assist the patient in making his [sic] own decision concerning a course of action" (p.282). Additionally, the self-help movement empowered patients with a consumer perspective of medical care.

Consequently, the desirability of the partnership model is recognized on both sides of the doctor-patient relationship. Patients began

indicating a desire for more information and participation. Physicians, as discussed earlier, began to understand its therapeutic and practical value through research that indicated that patients who were informed and involved in treatment decisions were more likely to follow treatment plans, have more realistic expectations, and better health outcomes.

The inclusion of partnership skills now pervades recommended psychosocial curricula (Kern et al., 1989; Korsch, 1989; Stewart et al., 1995). Teaching physicians the value of this concept along with actual facilitating skills to elicit patient input, comprehensive methods of informing and motivating patients to deal with medical problems, and negotiation skills to derive mutually agreed upon treatment plans are critical to the construction of sound doctor-patient relationships (Cohen-Cole et al., 1982; Burns et al., 1983; Quill, 1983; Novack et al., 1989; Stewart et al., 1995; Stoffelmayr, Hoppe, & Weber, 1989).

Managing Psychiatric Problems in Primary Care

Interviewing and doctor-patient relationship skills are important for many reasons. Among them is that they give primary care physicians tools to gather the types of information crucial to recognizing and treating the common, and often chronic, emotional and psychological problems that their patients present. It is ironic that although approximately 60% of mentally ill patients are treated by primary care physicians (Reiger, Goldberg, & Taube, 1978), it is not unusual for many patients' psychological problems to go undetected or to be misdiagnosed (Katon, 1982; Stewart, 1995).

Depression is illustrative of this point. It is far more common for patients experiencing depression to see their family physician than to seek out psychiatric help; furthermore, it is not uncommon for the depression and

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other psychiatric problems to be masked in physical complaints. Indeed, this appears to be how over half of all patients with psychiatric problems initially present to the physician (Goldberg, 1979).

Physicians need to be educated to gather the appropriate information, to recognize psychological and emotional problems, to give verbal support during interviews, and to develop treatment plans with the patient. In addition, they must learn to apply these skills to diverse populations. Primary care physicians see patients spanning the age spectrum from childhood to old age. Educators advocate that residents learn to distinguish organic mental disorders from psychological mental disorders, to diagnose and manage different types of depression and anxiety, to recognize substance abuse and its relationship to stress and emotional problems, and finally, to have a sufficient understanding of psychopharmacology to accompany their diagnostic skills.

The Michigan State University Psychosocial Curriculum

The psychosocial medicine curriculum at Michigan State University has incorporated all of the components outlined in the preceding section. Based on the biospsychosocial model of medicine, the overriding goal of the curriculum is to produce physicians who are patient-centered. This means that physicians see the patient as a whole person, not as a set of biomedical symptoms.

Patient-centered physicians approach medical encounters with the intent of meeting the patient's biomedical and psychosocial needs--as defined by the patient. This is not an easy task; it requires acknowledging patient cues and actively pursuing them and demands mastery of interviewing techniques, partnering skills, and self-awareness. Clearly this level of

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skill is not acquired through once-a-week sessions; it is best attained through intensive training that includes thought and practice (Smith, Marshall, & Cohen-Cole, 1994).

In developing the curriculum, attention was given not only to the content of the course, but also to teaching methods that have been recommended to produce an effective learning environment. Included among the methods are: presentation of specific learning objectives, direct observation and feedback, standardized presentations of material, roleplaying, demonstrations, and tape reviews (Carroll & Monroe, 1980; Kern et al., 1989; Williamson et al., 1992).

During the first year of residency at MSU, family practice and internal medicine residents are required to spend one of thirteen four-week rotations learning psychosocial medicine. This intensive training includes cognitive and experiential learning components supervised by a multidisciplinary faculty from departments of communication, psychiatry, family practice, and internal medicine.

The cognitive portion of the rotation refers to a series of seminars given three times a week that complement reading materials provided to the residents. A variety of topics are explored through group discussion, demonstration interviews, and role playing. These include: patient-centered interviewing, personality assessment, countertransference (self-awareness), somatization, physician-patient relationships, patient education and motivation, mental status evaluation, organic mental disorders, affective disorders including depression, psychiatric diagnoses, and psychopharmacology.

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The material introduced cognitively in the seminar sessions is reinforced by field experience. Residents spend most afternoons during the rotation in the company of a faculty member conducting bedside interviews with patients on the internal medicine or family practice services at one of the university-affiliated community hospitals. Residents are encouraged to identify several patients and, with the patients' permission, follow them during their hospital stays. The goal is to learn patients' psychosocial stories through using patient-centered interviewing techniques.

During these afternoon hospital rounds, faculty occasionally interview patients to demonstrate specific techniques and processes. Residents receive feedback from both their peers on the rotation and from the attending faculty member. When residents round with faculty from psychiatry, additional effort is made to identify patients with organic mental illness, affective disorders, or other common psychiatric problems seen in primary care to help residents learn to recognize symptoms and also to use appropriate interviewing skills.

To ensure that there is time for more thorough, and more private, feedback, residents also audio record interviews with patients either in their outpatient clinics or in the hospital for semi-weekly review sessions with peers and a faculty member. These sessions provide opportunities for more reflective analyses not only of interviewing techniques, but also of behaviors that may impede progress in developing relationships with patients--putting the self-awareness training into practice.

Although many of the curriculum objectives are derived from Lipkin, Quill, & Napodano (1984) and are consistent with other educators' recommendations (e.g., Burns et al., 1983; Cohen-Cole et al., 1982; Kern et

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al.,1989; Novack et al., 1989; Smith & Hoppe, 1991; Smith et al., 1991; Smith, Marshall, & Cohen-Cole, 1994; Stewart & Roter, 1989; Stewart et al., 1995; Willamson et al., 1992), they also reflect the accumulated experience of others who have taken MSU's psychosocial rotation. As part of the learning experience, residents are asked to determine their own objectives in the form of specific personal issues related to patient care that they would like to work on during the rotation. These might include learning to be more comfortable with silence, or working more effectively with controlling patients.

These learner-centered objectives provide the basis for group discussion and interview feedback. The development of individualized or learner-centered goals has the added benefit of demonstrating partnership building (see Knowles, 1986 for a discussion of learner-centered learning). In essence, the learner-centered portion of the curriculum is the counterpart to patient-centered interviewing--hoping to meet all the needs of the learner. (See Smith, Marshall et al., 1996 for a detailed description of the training).

In an ideal world, the MSU curriculum, incorporating the recommendations and experience of educators and researchers in psychosocial medicine, primary care, and health communication should be highly effective and valued by residents. It has the endorsement of a large segment of the primary care community for a variety of reasons outlined previously. Furthermore, quantitative assessments of the curriculum have demonstrated its efficacy. For example, recent studies showed that residents receiving the MSU psychosocial training had greater self-efficacy regarding performance of psychosocial skills than untrained residents, and

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that their actual performance of interviewing skills was superior to untrained residents. In addition, patients' of trained residents had fewer somatic complaints and higher patient satisfaction compared to patients of untrained residents (Smith, Lyles et al., 1996). Nevertheless, the degree to which the training is actually used and valued by its recipients is, in reality, an empirical question.

Summary: The Meaning of Psychosocial Education in Medical Practice

Sandwiched between cardiology, neurology, general hospital in-patient assignments, and other medical rotations, the four-week psychosocial medicine rotation appears on first-year residents' schedules when they report for orientation July 1. It is met with a range of enthusiasm. Residents who have trained in medical schools outside the U.S.A. often have little idea of what the rotation entails. Most U.S.A. medical schools give some degree of psychosocial training which produces reactions from "I have already had this" to interest in having more.

This preceding chapter has summarized the context in which psychosocial medicine training came to be a part of primary care medicine curricula. In the last sections, the emphasis has been on the historical and societal influences that supported its evolution. It should not be forgotten, however, that first-year residents thrown into four weeks of psychosocial training are not far removed from the socialization process that gears them toward biomedicine and the self-protection of detachment.

Residents in this rotation also have varying levels of interest in primary care. Although some of these men and women chose medicine with the idea that they would become primary care physicians, some will use the first year of residency as a stepping stone to specialties outside of primary

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care; others will specialize after completing a primary care residency. In any case, they will experience the competing forces in their first year of residency between the need to master biomedicine and technology and their personal desire to retain their humanistic and altruistic motivations.

For all the endorsement of psychosocial medicine and the general consensus of its importance in medical training, the influence of the training in actual medical practice remains unexplored. There is implicit evidence that its value may evolve over time. For example, Palchik (1990) noted in a study of information-gathering for diagnostic purposes that students emphasize the importance of diagnostic tests while physicians (in practice) placed greater emphasis on history-taking. In addition, Linn et al. (1986) reported that when 154 internal medicine physicians were asked two years following residency to evaluate their training, one of the major areas in which more knowledge was desired was managing psychosocial problems.

Stewart and Weston (1995) remarked that students, while learning their patient-centered model (the content of which is consistent both in philosophy and in application with MSU's psychosocial medicine rotation), often revert to old methods when rushed or under pressure. They sometimes have difficulty integrating all facets of training: "It takes considerable experience with the patient-centered model before it becomes second nature" (p. xxiii). Moreover, it requires more than practice alone to learn, use, and value a new, and much more complex approach to patients (Weston & Brown, 1995). Citing Perry's (1970, 1981) theory of intellectual and ethical development in adults, Weston and Brown (1995) noted that "learning requires the students to make sense of their own experiences" and that "it takes time to come to terms with their new insights" (p. 124).

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This factor, coupled with the notion that the development of self-awareness, a crucial element to successful integration of the training, is an evolving process, suggests that the meaning and impact of the psychosocial medicine rotation evolves over time as well.

Psychosocial training is necessarily communication training. During the psychosocial rotation, a variety of communication skills are taught. Residents learn basic interviewing techniques to encourage patients to open-up--to tell their stories; they learn how to elicit and respond to patients' expressions of emotion; they learn methods of communicating effectively with somatizing patients; and they learn techniques of conveying health information and motivating patients to change risky health behaviors. They also practice--rehearsing the actual words required to enact what they have learned with their own patients. In essence, they are given a philosophy of delivering patient care that includes methods of applying it.

It is evident during the four-week rotation that residents <u>can</u> learn to perform these skills. The question becomes to what extent do they actually integrate the biopsychosocial model and patient-centered interviewing into their own medical practices. Specifically, how do they work with their patients following training? Which, if any, of the skills is most important to them as physicians in practice? How do they perceive these patient-centered interviewing skills influence their relationships with their patients? How has the enactment of patient-centered interviewing influenced them personally? Is there evidence of personal growth through self-awareness? The purpose of this study is to explore these questions through qualitative analysis of interviews conducted with physicians two to eight years following their psychosocial medicine experience.

McWilliam (1995) suggested that qualitative methodologies are appropriate for studies involving the doctor-patient encounter because they "promote understanding of the subjective, intuitive, dynamic, interrelated, context-dependent experiences of human life" (p.204). Furthermore, she noted that grounded theory methodology (Strauss & Corbin, 1990) is appropriate for addressing and "articulating the theory of medicine--in particular, the connections among human experience, life events, human relationships and health and ill health" (p.205). That methodology has been chosen for the analysis of the data in this research; the following chapter provides details of its methods.

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CHAPTER THREE: METHODS

The procedures outlined here were implemented to determine the influence of teaching psychosocial medicine on medical practice. Data for this study were gathered in conjunction with a five-year project evaluating the efficacy of a psychosocial medicine rotation for first-year internal medicine and family practice residents. The focus of this segment of the evaluation was an exploration of the long-term impact of the training on physicians' skills, attitudes, relationships with patients, and ultimately on patient health. To accomplish this end, qualitative analyses of interviews with psychosocially trained third-year residents and graduate physicians were conducted.

Sample and Procedures

Three groups of physicians who completed psychosocial training during their first year of post-graduate residency (PGY1) were identified for inclusion in this study: 1) Thirteen family practice and internal medicine residents who completed the psychosocial medicine rotation in 1991-1992; 2) a second group of seventeen family practice and internal medicine residents who completed psychosocial training in 1992-1993; and 3) eight internal medicine and family practice physicians who completed psychosocial training between 1986 and 1990 and were currently pursuing fellowship training or practicing medicine in the surrounding community.

Residents receiving psychosocial training in PGY1 were

contacted for interviews in their third year residency (PGY3). Consequently, interviews were conducted in clusters a year a part. Of the thirty PGY3 residents who were identified for the study, 21 (70%) were actually interviewed. An additional resident from a previous class participated in a pilot of the interview protocol; that interview was included in the analysis as well. Seven of the 22 residents were women, fifteen were men. Of the 22, ten received their medical education outside the U.S.A., twelve within the U.S.A.; eighteen were internal medicine residents and four were family practice residents. Sixteen had M.D. degrees; six had D.O. degrees.

Nine residents from the two classes did not participate. Six residents (three from each program) had left their residency programs after the first year. Nevertheless, attempts were made to contact all residents. Unfortunately, seven had moved out-of-state; of those remaining in the area, one was unreachable and one declined. An additional eight graduate physicians who practice in the surrounding area were also contacted. They had received psychosocial training prior to the five-year evaluation project when the curriculum was somewhat less structured. Of those, five were willing to participate: two women and three men; four were previously internal medicine residents; one had been a family practice resident. All participants were asked to if they would be willing to participate in an audio-recorded interview to help evaluate the impact and effectiveness of psychosocial training. All participants were informed that their responses would be confidential and their participation completely voluntary. A total of twenty-seven interviews were completed.

Instrumentation

A semi-structured interview guide including participant instruction, information, and a facesheet for demographic data was developed following a format suggested by Lofland and Lofland (1984). The interview questions developed for the first set of follow-up interviews focused primarily on issues related directly to the psychosocial program; e.g, What is your perception of the psychosocial training program? How has it affected your work? Tell me what you use from the training.

The content of the second interview guide (and its iterations) was based on interview questions and responses from the first set of interviews. In accordance with the grounded theory concept of theorectical sampling (Lincoln & Guba, 1985), additional questions and probes were incorporated to help develop a clearer understanding of the impact of psychosocial training on medical practice (see Appendix for initial and final versions of the protocol). For example, participants were given a scenario in which a new patient makes an appointment for a complete physical because of indigestion. The participants were then asked how they would structure a medical interview with the new patient; what they would specifically say and do upon encountering the patient. After their initial response, participants were given more information that clearly indicated that this new patient had no organic disease. Participants were then asked what this patient would be told on the return visit and how the patient would be approached.

The first section of the interview guide primarily addressed general communication patterns with patients and training in residency that was useful in developing those interaction patterns. The second section

consisted of a series of open-ended questions that allowed participants to identify the primary components of the psychosocial medicine rotation (i.e., interviewing techniques, self-awareness, emotion-handling skills, patient education techniques, and somatization skills) that were most relevant or irrelevant to their medical practice, to describe the context and conditions in which they were most relevant, and the potential outcomes derived from their use.

As participants were interviewed, additional questions and probes continued to be incorporated to elaborate theoretical variables that presented themselves. This iterative process is integral to qualitative analysis using grounded theory procedures (Glaser & Strauss, 1967) and is described in detail in the analysis section that follows.

Data Preparation

Interviews were conducted by two members of the psychosocial research team. All interviews were audiorecorded and statements by both the interviewer and the interviewee were transcribed. Because the focus of this study was on the content of the interviews rather than conversational structure, no detailed markings illustrating inflection, talk-overs, or interruptions were made. Transcripts were checked for accuracy by selecting portions of the tape and comparing the text to the recordings; no problems were apparent in this regard. On average, the first set of interviews conducted with the original protocol took approximately one half hour. The second set of interviews lasted a minimum of forty-five minutes and averaged slightly more than an hour generating fifteen to twenty pages of transcript.

Several copies of the transcribed interviews were prepared so that

they could be grouped in a variety of ways to expedite coding and analysis procedures.

Data Analysis

Grounded theory procedures and techniques were used for data analyses. The following overview of procedures first described by Glaser and Strauss (1967) relies heavily on the recent explication of grounded theory techniques by Strauss and Corbin (1990) which is recommended for readers who are interested in more specificity.

Grounded theory methodology uses systematic procedures to develop inductively-derived theory from qualitative data. Phenomena are identified in primary data; conceptual labels are applied and concepts are then grouped into categories; relationships among categories are explored, developed, and checked again in the primary data. Strauss and Corbin (1990) encouraged researchers to develop and use theoretical sensitivity (acquired through exposure to research literature and/or from personal and professional experience) to help identify subtleties and meaning in the data. Indeed, Strauss and Corbin (1990) asserted that there is a constant interplay between deductive and inductive processes. However, in the final analysis, the categories and their relationships--the theory--is always limited to what actually occurs in the data (Strauss & Corbin, 1990).

Coding procedures. To ensure the integrity of the analysis process as well as a systematic approach to theory building, Strauss and Corbin (1990) outlined three coding procedures central to grounded theory: open coding, axial coding, and selective coding. These coding procedures, guiding the researcher from observation to theoretical abstraction, can be used on a variety of data sources including field notes, interviews, and

archival documents; and can be applied by line, sentence, paragraph, or complete document. Although the description of the coding procedures imply sequence, they may occur concomitantly.

Open coding refers to the first level of assigning conceptual labels to phenomena that occur in the data. This is accomplished, in part, by making comparisons and asking questions. Strauss and Corbin (1990) provided an example illustrating this process: A researcher collecting data in a restaurant may wonder what an individual restaurant worker's role is. The researcher may note that the worker is answering employee questions, appears to be noticing everything that is going on in the dining room, and is keeping track of everything. These phenomena are initially identified by the researcher asking him/herself, "what is this person doing?". They are subsequently given conceptual labels of "information passing," "attentiveness," and "monitoring." After watching for some time, the researcher observes and labels other activities and begins to compare the concepts with one another; like concepts are grouped together into categories; e.g., attentiveness becomes part of the category, "qualities of a good food orchestrator" (Strauss & Corbin, 1990; p.66).

In the axial coding phase, categories and subcategories are then further developed in terms of dimensional properties such as frequency, duration, and intensity. This phase occurs concomitantly with open coding and also involves connecting categories with subcategories. The context in which the category appears; the conditions and intervening conditions under which it is present; and the strategies and consequences that relate to the

conceptual category are all explored in the data. Strauss and Corbin (1990) illustrated the axial coding process with the following model:

CAUSAL CONDITIONS--> PHENOMENON--> CONTEXT--> INTERVENING CONDITIONS--> ACTION/INTERACTION STRATEGIES--> CONSEQUENCES (p.99)

The data may present themselves in a sentence such as: " When I have (condition) arthritic pain (phenomenon), I take aspirin (strategy). Later, I feel better (consequence)" (Strauss & Corbin, 1990; p.98). The concept of pain relief (the consequence in this case) can then be developed in terms of dimensions such as duration and degree. Additional data are then systematically and purposefully explored for more examples and/or verfication of conditions, strategies, and consequences of pain as well as the "dimensionsal locations of data (events, happenings, etc.) indicative of them" (Strauss & Corbin, 1990; p.107)

These focused coding procedures require the employment of meticulous recording techniques. Strauss and Corbin (1990) suggested numerous ways of methodically logging notes, using logic diagrams, miniframeworks, and/or memos. From these notes, hypothetical relationships between categories and subcategories may be proposed, but, as always, must be verified in the actual data.

Selective coding marks the beginning of the final of phase grounded theory development. In this phase, categories are integrated to form theory, necessarily requiring a higher level of abstraction than previous coding procedures. First a "story line" (Strauss & Corbin, 1990; p.119) is explicated by searching for the central theme in the data. This is accomplished by thinking in terms of the summary findings, the essential message of the study. From the descriptive story line, a core category--a

conceptual label that fits the story--is determined and its properties developed.

The core category is then linked with other categories; intervening conditions are also identified and explained; e.g., why the core phenomenon affects one person more than another. Eventually a statement of the grounded theory is developed. Once again, the researcher returns to the original data to validate the statement and to order the categories appropriately. The theory is compared to the data to see if it fits the cases in a general way. Cases that do not fit may indicate a state of transition or an intervening variable, either of which must be explored and incorporated into the theory adding both conceptual specificity and density.

Process in the data. Grounded theory procedures constitute a fluid process, moving between inductive and deductive reasoning, from one coding procedure to another. Process, however, is an important component not only to the procedures, but also to the developing theory. Embedded in the procedures are the mechanisms to capture the process in the data.

Strauss and Corbin (1990) defined process as either "stages...of a passage along with explanation of what makes that passage move forward...or as a nonprogressive movement; that is, as action/interaction that is flexible, in flux, responsive, changeable in response to changing conditions." (p.157) Consequently, the data are investigated for links between action and interactional sequences; for the changes in conditions that influence those sequences; for the responses to changes; and the consequences of the change (Strauss & Corbin, 1990). In the study described in this dissertation, for example, one area that was explored was

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sequences/conditions that precipitate the use of specific interviewing techniques.

Sampling procedures. Unlike quantitative research where large numbers of subjects help to ensure generalizability and stablity, grounded theory samples focus on the representativeness of a phenomenon in the data with the objective of specifying under what conditions the phenomenon exists.

Sampling procedures parallel the coding procedures previously described. For example, in open coding, the researcher's aim is to identify as many relevant categories as possible. For that reason, initial sampling should be open as well; i.e., early interviews should not be too highly structured (Strauss & Corbin, 1990). Throughout data collection, analysis sessions should follow closely so that concepts can be identified or verified and appropriate new questions can be incorporated into subsequent interviews.

Similar sampling procedures are followed in regard to developing relationships among the categories (axial coding). Sampling at this level requires covering all possible dimensions of a category and often occurs during interviews by asking questions about context, changes in a phenomenon over time, and consequences of certain conditions. The final sampling procedure accompanies the selective coding phase. As its name implies, discriminate sampling is more specific and is aimed at verifying the story line. Additional interviews or return interviews may be sought specifically to determine whether relationships hold up.

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The procedures and criteria of grounded theory methodology provide a means of systematically examining qualitative data and and developing them beyond description. Charmaz (1990) pointed out the flexibility and open-endedness inherent in this approach and the opportunity provided by it to examine an issue thoroughly: "A grounded theorist may sculpt fully contoured ideas throughout the analysis rather than only suggesting or alluding to them at the end " (p.1168). For these reasons, grounded theory methods appear to be an excellent choice in the exploration of the meaning of psychosocial training in medical practice.

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CHAPTER FOUR: RESULTS

In this chapter, results are presented of intensive interviews with third-year residents and practicing physicians who received psychosocial training as part of their PGY1 residency experience. Using the research questions to guide the analyses, transcribed interviews were reviewed in detail for manifestations of patient-centered care and its significance in medical practice.

It is clear from the interviews that the elements of the psychosocial training were integrated into patient care in varying degrees by the participating residents. Three distinct groups emerged representing multiple levels of training influence.

Training influence is defined here as the degree of use of patient-centered skills accompanied by the attribution of skill acquisition or improvement to the psychosocial training curriculum. Training influence fell into three categories: (a) a total-effect group who found virtually all of the elements of the training meaningful, who incorporated the skills into their work with patients, and who attributed the use of the elements in large part to the psychosocial training; (b) a partial-effect group who found most aspects of the training useful, but applied them more narrowly than the total-effect group; and (c) a minimal-effect group who found only superficial value in the training and felt that much of the curriculum was intuitive.

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Composition of the groups. There is diversity among the thirteen residents for whom the psychosocial rotation was most helpful. At the time the interviews were conducted, the total-effect residents ranged in age from twenty-seven to forty-four with a mean age of thirty-four. Their ages when starting medical school ranged from eighteen to thirty-one, averaging 24.8. Seven had had the experience of having a close friend or family member hospitalized; five had been hospitalized themselves (four of these had dual experience); four had had neither experience. Data were unknown for one resident. Ten total-effect members were internal medicine residents, three were family practice residents. Eight of the group are males, five females; seven graduated from U.S. medical schools, six from international medical schools; and nine are M.D.s and four are D.O.s (see Table 1 for summary of group composition).

Among the five members of the partial-effect group, ages ranged between twenty-nine and thirty-four at the time of the interviews with a mean of 31.8 years. They had entered medical school between the ages of seventeen and twenty-six with a mean age of 20.6. Three of this group had experienced having a family member or close friend hospitalized; none had had that experience personally. Four members were from internal medicine and one from family practice; four are males, one is female; three are international medical school graduates, two are from U.S. schools; two are D.O.s and three are M.D.s.

Only four internal medicine residents, all M.D.s, comprise the minimal-effect group. Three of the four are males, and three of the four graduated from U.S medical schools. They ranged in age at the time of the interviews from twenty-nine to forty with a mean age of 35.25. Members

had started medical school between the ages of seventeen and thirty-three with an average starting age of twenty-five. One had never been hospitalized nor had experienced having anyone close be hospitalized; two had experienced being hospitalized; two, one of whom had the dual experience, reported having people close to them hospitalized.

Observed concurrently with the levels of training influence was another core construct, communicative confidence. This refers to a sense of personal comfort and self-efficacy in talking with patients, in dealing with highly emotional and sensitive issues that patients express voluntarily, and in eliciting those issues when they are only suspected. Residents' level of training influence was related to their reports of increased personal comfort, willingness, and interest in exploring a variety of topics. The confidence expressed about communicating with patients and the skills used to do so frequently carried over to colleagues, family, and friends as well.

In the pages that follow, the levels of training influence and their relationship to communicative confidence are presented in conjunction with the primary research questions posed at the conclusion of chapter two (e.g., To what extent is the biopsychosocial model integrated into medical practice? How does the use of patient-centered skills influence both physicians and their relationships with patients? Is there evidence of personal growth through self-awareness?). The results are presented separately for each group. For the total-effect group, first evidence of the group's integration of the biopsychosocial model is discussed in the context of the residents' use of skills. Next, the perceived value and the influence of the skills and training is presented. Finally, evidence of self-awareness is explored. The results of interviews with the partial and minimal-effect

residents follow.

Following the residents' results, highlights of the interviews with practicing physicians are summarized in the context of the residents' interviews. Throughout this chapter, excerpts from residents' and practicing physicians' interviews are used to illustrate and punctuate the research findings. In compliance with the human subjects committee's requirements on confidentiality, no identifying markers are used with the quotations. Italics are sometimes used within the quotations to add emphasis.

Levels of Training Influence

The Total-Effect Group

A resident described working with patients' personal problems. What came to her mind was a patient who had died two weeks previously. She had met the patient only eight months earlier when the patient came to her for a physical examination. On the patient's second visit, the resident had to deliver bad news.

> My second visit with her was to tell her that she probably had cancer, and to work with her on this. I emphasized the whole time that I was there for her and that she could call me...that this was going to be a difficult period--a period of not knowing for sure...and that this would be kind of scary for her.... We kind of role played: "How would you want me to tell you that this is not a cancer or if this were a cancer?" It was good because it turned out that she had a significant cancer. She called me a lot....I called her, "You come in; we need to talk about some things".... and I always took cues from her--how much she was willing to be told

> at that point...."Do you want to know more? Do you feel you know enough?" I was always checking with her and I always told her the truth. So we were able to completely make decisions about hospice care, where she wanted to be in her final days, whether she even wanted to be hospitalized. She brought in her sister; she brought in a good friend; her husband. So I was able to work with her and we talked about close friends. Her final days were at home with the care of hospice, and she expired at home....To me it was the best--exactly how I would want it to go for me if I were a patient....I had a patient that I followed from the beginning to the very end and in a very patient-controlled manner; I totally went by her cues and I was able to work within what we could do medically.

The spirit of patient-centered medicine is embodied in this resident's story: working together with the patient, following the patient's lead, attending to cues, and recognizing that the "best" medical treatment cannot always be a cure, but may be instead providing respect, support, and comfort.

For over half of the residents interviewed, the psychosocial training had a profound effect on the practice of medicine and developing a patient-centered approach. Extensive use of the full spectrum of interviewing skills and evidence of self-awareness, the essential components of patient-centered medicine, were manifest in their interviews.

In describing work with patients, this group demonstrated a clear understanding and enactment of the biopsychosocial model and used the interviewing skills taught during the rotation with the intention of improving

their relationships with patients and ultimately patient care. Moreover, they recognized the need to be conscious of their own reactions to patients so that the care of the patient would not be compromised. The sections that follow recount the total-effect residents' work with patients.

Integration of the Biopsychosocial Model: Using Interviewing Skills

Interviewing skills is an umbrella term comprising agenda setting and management, directive and nondirective facilitation, and handling emotions. Residents in the total-effect group integrated these techniques with their personal styles in conformance with the patient-centered models taught in the curriculum.

Opening the interview. When asked how they actually interacted with new patients, it was common among members of all effect levels to mention greeting patients and asking open-ended questions such as, "What brings you here today?" The total-effect group, however, was distinctive in several ways. They were generally more explicit and contemplative in responding--as if they were actually envisioning a new patient as they answered. They were more likely to mention introducing themselves, not just as a pro forma convention, but as a matter of consideration as illustrated in the following:

> First I would introduce myself--tell the patient who I am because I'm about to ask them a lot of very personal things. So I would start by telling them *who I am*....

This resident was referring to the fact that she tells patients a little bit about herself (e.g., "I'm in the third year of my residency and moved here from _____") before questioning them. Implicit in this act is the understanding that relationship-building and its components, disclosure in

this case, are reciprocal processes. Respect for patients--as people, as partners--was fundamental to the total-effect group's understanding of the practice of medicine and was apparent in both minor and major actions with their patients. They were often specific in their reasons for asking open-ended questions at the beginning of the interview; e.g., to allow patients to talk without interruption, to ensure patients can say what is really important to them. As might be expected, this group of residents also tended to be more attentive to details of interactions. For example, they typically noted aspects of their own nonverbal communciation along with the verbal account:

> Basically, I come in and introduce myself and ask, "How are you feeling today?" and things like that...and what I like to do is just let people talk... so I try to come in, *do a firm handshake without overpowering, make eye contact, don't appear that I'm pressed for time even though I may be.*

> Usually when I first come in the room, I tell them who I am, *shake their hand and get down at eye level with them*--and open up with a question like, "What brings you here today?" or, "What can I do for you today?" so I can get an idea and just start with whatever they want.

These responses suggest a conscious approach to the interaction and a recognition that common courtesies apply in a medical encounter. To these residents, the encounter begins with the notion that the patient is a person one happens to meet in the doctor's office.

The residents' attentiveness to communicative details was not

limited to their own behaviors. Appropriately, they were more focused on reporting the behaviors they watch for in their patients. A recurring theme in these interviews was the importance of the opening minutes of the interview to listen for and to pick up patient cues.

> I walked into the room and introduced myself. We started talking a little bit about why she was there and I noticed that she was avoiding eye contact for most of the interview...I really let her run the show as far as giving me information without really being directed and then I asked her if she felt uncomfortable talking with me and that I had noticed that she wasn't looking at me and I wondered if I had done anything to offend her or something like that. She said, "No," and started crying and talking about the fact that she was in an abusive situation.

> You need to listen to the other things that they are saying or sometimes what they are not saying...the patient who comes in and says it's for a sore throat. But as you listen...to them sigh, and the fact that they don't make eye contact, and their concentration seems a little off...those are cues for depression....

> When people seem more anxious than I would expect them to be, or making a big deal out of what is apparently a small complaint, that's when I usually suspect that they have a fear of something dreadful....

The range of patient cues illustrated by the previous excerpts relates to the interviewing skill level of this group. In his textbook on

patient-centered interviewing, Smith (1996) noted that listening to patients at multiple levels--considering how patients say something, what is unsaid, and what is implied--is advanced work. It requires "attention to subtleties of grammar, syntax, verb tense, changes of subjects, nonverbal cues, incongruity in verbal and emotional content, and the understanding of metaphors" (p. 51). The total-effect group attended to many of those subtleties.

Whether stated overtly or implied, it was clear that with members of this group, patients were allowed minutes of uninterrupted talk during which the residents gave unwavering attention. Specific use of open-ended requests and other facilitators such as silence were mentioned frequently. This is not to imply that these physicians relinquished all control of their patient interviews. Rather, they gave patients ample opportunity to bring forth an agenda.

> If you just let people talk...if you just leave them alone and not interrupt them and not direct them at all, they usually give you the diagnosis...give them five minutes without interrupting them at all and 80% of your questions will be answered.

Control of the interview was exerted in a manner consistent with the elements of the psychosocial training. For example, residents indicated that they used focusing questions to pursue patient-initiated topics. Some residents specifically mentioned the use of agenda-setting skills at the beginning their interviews to indicate time constraints from the outset and to ensure the most important patient and physician needs were met. Others were pleased with other time management skills that had developed through the psychosocial training; i.e., their abiliity to refocus conversations and get

patients back on track without being offensive. For them, the training helped to identify appropriate times for transitions and the accompanying phrases to accomplish them:

> Agenda setting is particularly helpful in those patients who are not very focused and tend to kind of go off on tangents...I'd come in and say, "What are the three things that you'd like to talk about today? There are things that I need to talk to you about today, too."
>
> If they come as a new patient...with a list of ten to twelve problems--on a first visit you just can't do all of that so I try to narrow it down by asking, "What are the two most important things you would like to address?"
>
> And then of course there are some patients who if they want to tell something that would take five words, they are going to take an hour to say it. Those are patients who are sometimes very difficult; you have to find a way of streamlining them and making your time with them most efficient, and I think that the rotation helped me to do that.

There was remarkable consistency in the total-effect group's accounts of the use of the basic interview structure, interview management, and facilitative skills taught in the psychosocial curriculum. No skills were more frequently mentioned and described in more detail, however, than the emotion-handling skills.

Emotion-handling skills. Like open-ended questions, emotion-handling skills were mentioned and appeared to be employed universally in all effect level groups. What varied among the groups was the purpose for which they were used and their perceived value. Among the total-effect group members, there was evidence that emotions were sought in addition to being handled. The attention to emotion on both dimensions reflects the heart of patient-centered medicine. Actively seeking emotions indicates an understanding of both the patient as whole person and of illness and health as more than biological symptoms.

> I feel like if I find an emotionally-charged issue that I'd better find out more about it...I think perhaps the training we've received has been helpful in realizing how much emotion is not an undercurrent, but may actually be the complete issue in a lot of people's illnesses.

Residents in this group not only sought more emotional information under conditions when there was an issue that surfaced verbally, but also when the issue was unstated. The excerpt below is from a resident who talked specifically about how he learned to address emotion in the psychosocial rotation.

> One of the things I remember learning is just saying what you felt at the moment. For example, a patient would start to cry and before you may have felt uncomfortable and said, "I'm going to go look at some x-rays" and kind of muddle up the situation. One of the things that was impressed upon us was: Why not just say what you are seeing? Which is, "You look really sad; talk to me a little bit about that and how you are feeling."
>
> During the psychosocial rotation, residents were taught the

mnemonic, NURS as an easy reminder of the basic emotion-handling skills. It stands for phrases that can be used Naming, Understanding, Respecting, and Supporting emotions. In the preceding example, the resident named the emotion he saw for the patient. Even if he had not followed it with a request to talk more about feelings, the patient would most probably have opened up because, as another resident noted, "to name an emotion is to give permission to talk about it."

Residents repeatedly mentioned the importance of validating patients' feelings and offering support. Several explicitly recalled the mnemonic and gave examples of of the phrases that they use: "If I were in your situation, I'd feel sad as well," or "I can see that you're angry and I can understand how being in that situation can be very upsetting and difficult."

Emotion-handling skills were not used merely to "get through" a difficult or uncomfortable moment in an encounter with a patient. They were used as an important access point in understanding the patients' concerns and the nature of their physical symptoms. Furthermore, the use of the skills was considered therapeutic by the total-effect group.

> ...the interviewing kind of niched into where she got back to her feelings and she ended up opening up and crying and expressing some emotion. I think it was very difficult for her, but it was good....I just let them have some silence, or just reach out and touch their hand or something, but I won't try to interrupt what's going on with more conversation. I just try to let them drain a little bit.

Evidence of conviction in the validity of the biopsychosocial model

and the enactment of that conviction using patient-centered interviewing skills infused the total-effect groups' stories about their patients. Although to this point the discussion has focused on the residents' use of various skills as isolated elements, that is not the reality of patient-centered interviewing. The skills are used in concert as in the following example.

One resident was particularly detailed in an account of a young diabetic woman whose blood sugars were "wildly out of control." He noted that sometimes things are happening to patients that relate to their medical care and "if you don't ask about a change in affect that you detect, you would never know."

> You have the feeling that there is a facade there; that there is a covering--she's hiding something. She's not letting things out. One day I sat down and said, "It just doesn't seem that you are telling me everything." And she said, "I'm having trouble with my mom." I said, "Tell me about it." [and she opened up...] Apparently her mom has an eating disorder; she's bulimic...she has a real body image problem--she is very tan and still goes to tanning booths. She eats like anything, takes diuretics, takes laxatives. And this stresses her daughter who really loves her....and the stress is making her [the daughter's] diabetes even more difficult to control. So we got the social workers to see what they could do to intervene, and help get this family back on the road.... And now what they've done is they have got [the daughter] and her mother going to a class on eating disorders--where they generate from--and hopefully that will help. If we can get the mother on line that will help her daughter.

In this account open-ended requests, attention to patient cues, pursuit and consideration of emotions, social context, and physical symptoms are integrated to develop a treatment plan. The recognition that treating patients requires knowing them--their emotions, their social contexts, their psyches is typical of the total-effect group. Not surprisingly, this group's members also proved to be adept in managing somatizing patients.

Managing somatization. Working well with somatizing patients requires the use of all the components previously discussed with the addition of patient education and negotiating techniques. Indeed, effective management of somatizing patients may be the most comprehensive test of patient-centered skills. A severely somatizing patient is the consummate difficult patient. These patients have chronic symptoms for which no organic disease cause has been discovered despite numerous diagnostic tests and medical appointments. Somatizers are usually frustrated and often depressed. Previous explanations of their symptoms have often been inadequate. It is not unusual for a somatizer to have been told that the symptoms are imagined, "all in your head." Because their complaints persist, they are frequent users of medical services. They are inclined to request numerous diagnostic tests, to doctor shop, to use ready care facilities and emergency rooms, yet are distrustful of the medical system because their symptoms never improve. The psychosocial training specifically addresses the needs of somatizing patients and the way those needs are best met (see Smith, 1991).

First, residents are taught to give an honest appraisal of their medical problems by informing the patient of the diagnosis in terms of "good and bad news." The good news is that the symptoms are not due to

anything life-threatening. The bad news is that there is no cure; however, improvement and symptom control are very possible. Second, the training emphasizes reassuring the patient that the symptoms are real, providing a clear explanation of the mind-body connection, and addressing the role of depression in symptomatology. This requires exploring stressors in the patient's life and relating them to the patient's physical symptoms.

Finally, a treatment plan must be negotiated with the patient that reaffirms a partnership approach and obtains a commitment from the patient to adhere to the plan. Although specifics concerning medications and exercise recommendations will vary, the plan always includes an understanding that there will be no further testing, no surgery, and no appointments with specialists. Instead, the primary care physician and patient will have a schedule of regular office visits (frequently initially) during which specific goals will be set for the next visit such as a reduction in habit-forming pain relievers and an increase in appropriate physical activity. This management process cannot be accomplished without a good doctor-patient relationship and necessarily requires use of facilitation, emotion-seeking, and emotion-handling skills throughout all medical encounters.

Using the somatization management model. Having a plan for working with somatizing patients doesn't eliminate the challenge they present. The total-effect group acknowledged the inherent difficulty in working with somatizing patients:

> They are more difficult I think than coming in with a straightforward medical problems; they are more difficult to manage...they are also a little more time-consuming.

In this group, however, the acknowledgement was likely to be tempered by compassion and an ability to see patients as individuals.

> There are some patients who have somatic dysfunction and present with bodily ailments that I believe are from stress or from their coping mechanisms or some type of emotional problem and some of them can be very trying... it can ruin your afternoon [smiles]. There are others, this gentleman I'm talking about... he's delightful.....I feel very good when he is on my schedule.

> I had one patient [with somatic symptoms] who was working in a nursing home and is now telling me her job [in combination] with her boss is extremely stressful. I do know that dealing with patients can be stressful...I told her it can be--"You're under a lot of tension at times," and I said, "What do you do for yourself during those times?...our bodies react to stress; our body reacts to things that make us more debilitated...your body is reacting to some pressures...together we can find out how to take care of that, to have some control over the some of the pressures that you have." So we can work from that angle.

Another resident expressed concern for patients with somatic complaints in a different context. She commented that she has been bothered working with attending physicians who don't offer somatizing patients hope for managing their symptoms.

> They say, "You've got fibromyalgia," and they really don't offer them a lot of positive hope [like] "I've treated hundreds of patients with this and we see dramatic results. And you, too, can

> be one of these people"--to give them that positive sense. It's more like, "You've got this and this is the program. And some people do better and some people don't." I feel like, gosh, if you would *just tell them some positive things*.

The residents in the total-effect group do tell somatizing patients positive things. When given a scenario that described a patient with somatizing symptoms (but did not label the patient as such) and asked how they would treat that patient, total-effect residents followed the model for managing somatization almost as precisely as it had been taught originally. They recounted how they begin talking to patients about the results of their tests and work on building a partnership.

> I...start out saying something about normal tests--"The good news is that there is nothing seriously wrong." And then I start validating their symptoms--that this might be a problem that *we* can't totally fix, that *we* might be able to make it better or make it more tolerable.

> Basically, I sit down and go over the findings that I found on the physical exam and also the findings in the old records that I have found to be in normal limits. I would go over all the different causes to the symptoms that you have....And since we have already covered tests for organic problems...cancer or colitis...and those tests were negative, the probability is leading us to look for other problems that cause these symptoms. Some of the problems could be related to...problems with depressive illness.....It's really important that further testing stop here and that we evaluate

> other reasons for this problem....It's very important that you say that, "the pain that you're having is real--that's obvious--."
>
> "You're not feeling good; you're not feeling the way you want to feel." And I talk about stress and I talk about being unhappy, and I talk about anxiety and depression and many times how it is very, very hard to identify things--for the physician and for the person who is experiencing [problems]. And I like to let the patient know we can work on this together....

The residents indicated that they develop a regular appointment schedule with these patients, and they offer the patients a supportive partnership.

> I try not to make promises, but say that I will do everything I can. *We* will work *together* and see if *we* can make you feel better. And [I] try to see them on a regular basis. I think patients respond well to that.

The thorough use of the somatization model is further testament to the incorporation and understanding of the biopsychosocial model by the total-effect group of residents. Effectively helping somatizing patients necessarily requires attending to the whole person and using the full spectrum of interviewing and emotion-handling skills taught in the curriculum. In the following section, the value and meaning of enacting patient-centered medicine is explored for the high-effect group: What it means to them personally and as physicians; its influence on the doctor-patient relationship; and the contribution of self-awareness to the practice of patient-centered medicine.

Effects and Value of Patient-Centered Training

Validation and new perspectives. By far, the majority of residents in the total-effect group came to psychosocial training with a favorable predisposition toward patient-centered medicine and some familiarity with the biopsychosocial model. For a few residents, exposure to those concepts occurred for the first time in the psychosocial rotation. In either case, both groups credited the rotation for profound changes in the way they conducted patient care.

Residents may have been predisposed to patient-centered medicine for a number of reasons. Most of the residents indicated it was something that they had always thought important without a specific attribution; some mentioned reinforcement of psychosocial approaches during medical school; some indicated a combination of factors that contributed to their psychosocial interest. The residents who were most explicit talked about personal experiences with the medical community that shaped their interest in communicating with patients as people.

> I personally experienced problems with the medical profession. My father was extremely ill and was in the intensive care unit for almost thirty days. It was extremely difficult for us as a family, not only because of my father's illness, but also dealing with the fact that physicians were not speaking to us. They were not communicating with us. We had questions; they were unwilling to answer them--that left a big impression on me the first year of medical school.

Similarly, another resident talked about how poorly she and her child had been treated during a life-threatening emergency involving the child:

> After spending hours in this clinic, I decided there have got to be people who are in tough situations [dealing with sick and dying children] who are in touch with the other side of medicine. So I wanted to be one of them and that is why, I guess, that I had to go on to medical school.... I thought about how I would like to be treated in those situations.

What is remarkable is that even these residents, who so very much wanted to have a psychosocial approach to medical practice, were not sure how to accomplish that goal. Moreover, they were not sure that the way they wanted to communicate with patients and families would be considered professional. Clearly, the psychosocial training offered during medical school was not enough. For this subgroup of the total-effect residents, the psychosocial rotation in post-graduate education validated their aspirations.

> What it allowed, the psychosocial rotation, was...it told me not only is this OK, what you're doing, but this is really the way it should be done. So it was positive reinforcement for what I had thought I wanted to do....That was really good for me.

> It was really important, I think, for me to get a really clear signal that it was OK to start talking about [psychosocial issues].... The month I spent on the psychosocial rotation was the first time anyone said, "it's your responsibility to sit down with the family," to take the rein, to kind of direct the whole situation, give them information, read the family and see how much information they want...and give a little bit more comfort.

It was also clear from talking with this group that wanting to communicate in a certain way is very different from knowing how. Just as with residents who may never have considered a biopsychosocial model, the psychosocial rotation provided the psychosocially-oriented residents with specific skills to convert sensitivity into action. Throughout the interviews, they consistently talked about the importance of the "tools" that they now have at their disposal. Most often they were referring to emotion-handling skills.

> I recall most of the phrases of encouragement and empathy. I deal better with patients' feelings of anger and frustration...having the resource of these phrases that were taught. When I have a message that I want to convey, there is this phrase that I have learned that sometimes works.
>
> It feels like you have a little armamentarium at your disposal so that you know how to deal with certain situations.
>
> In the past I wouldn't have even bothered [to try to elicit emotions]. To myself I would have said, "I wish I could help this individual; I wish I could give this individual a shoulder to cry on." But, I didn't know how to do it. And I think the rotation taught me tools that you can use without making the person feel that you are being too intrusive, [to convey] that it's a genuine caring that you have and that you are willing to help.

Residents predisposed to psychosocial medicine were also the ones for whom the time-management skills were most crucial. Their interest and proficiency in patient-centered medicine sometimes made them overly

solicitous with patients, making their efforts counterproductive. They needed skills to help them redirect the interview flow to ensure that other patients were not kept waiting and that the physical needs of their patients were met.

> Psychosocial teaching helped me to coordinate and do my time management a little better because I was a little haphazard initially in getting the physical part in or some of the pertinent history because I didn't know when to stop some of the personal issues, but I didn't want to discard that.

The residents who had a strong biomedical orientation prior to the psychosocial rotation did not differ from the other total-effect residents in their use or appreciation of the skills, nor in their assessment of the value of practicing patient-centered medicine. They differed only in that, for them, the psychosocial training was the quintessential "aha!" experience. These residents, all of whom were born and received their medical training outside the U.S.A., spoke of the psychosocial rotation as opening up "an entirely new dimension."

> Being an M.D., we are not really oriented to these kinds of issues [psychosocial]. We are trained mainly to deal with diseases. The disease itself, not how it effects the individual in terms of emotion-wise or psychosocial-wise.... So that has helped me a lot....now I know that there is always a limit to how we can treat disease, and then after that I get to address the emotional needs of the patient, too.

Benefits of using the skills. It is noteworthy here that the resident speaks about "getting" to address emotional issues as if it were a

reward. To the residents in the total-effect group this was the case. As was indicated in part by earlier excerpts, learning to competently elicit and handle patients' emotions was by far the greatest gift of the psychosocial training, both for their patients and themselves. The following comment is representative of their attitude. This resident begins by responding to a question asking whether there are times when he doesn't use emotion-handling skills.

> No, not really. I think emotions go with us. They are part and parcel of us and if you have the capability to probe and find out what is causing particular emotions, I think things go so much smoother when you get those emotions out into the open straight away. And then we understand that this person is angry because of this, is hostile because of this.... You get [patients] who come...and every day they are in pain. They're angry; they come in and you can see it on their faces. It's amazing how sometimes they leave, and you haven't [really] done anything. You just sat and talked with them and they feel more at ease....But you can see if you follow the patient for a while, you can see changes in some of these individuals. You can see that they are not as angry as they were when you first saw them. And that sometimes they are doing better in their lives. Their idea about how to cope with life changes.

The emergence of communicative confidence. " I don't like getting anger, but I can't say I'm afraid of it." Implicitly, and sometimes explicitly, residents revealed their new-found lack of fear in approaching difficult, emotionally-charged topics. One resident talked about working

with parents who faced a very high-risk pregnancy and had made a difficult decision to terminate the pregnancy:

> It's a very difficult time for them and *you just have to take the bull by the horns and realize that you have to let these people know you care,* and you understand some of the problems that they are going through, and it's okay for them to talk about their emotions, let their emotions out....You go in there and talk to them and let them know that you care and back away when they want privacy. *But keep going in there* and letting them know that you care about what happens to them, not only medically, but also socially and emotionally--and how you feel with this loss....If you are a physician, you have to be caring; you have to let the patient know that, yes, you are there; you can help; and you want to know what is happening so you can help. And I think this rotation does help you do that.

Repeatedly the total-effect group expressed willingness to work with patients' sadness, anger, hostility, and fear, and increased ability to deal with delivering bad news to patients.

> I think about what I learned in the psychosocial rotation...[when] I have to break the news to somebody who is dying of cancer or who is recently diagnosed with AIDS...the psychosocial rotation prepared me for that. I feel much more confident, more comfortable doing that.

Some residents framed their ability in terms of feeling more in "control" or more "comfortable" interacting with patients; the feeling that "nothing that they [patients] can throw at you will make you feel

uncomfortable."

> ...If I have an MI [myocardial infarction] patient, I'm in control of the situation because I've been trained to treat MIs. So in the same way I'm empowered to treat other things like cholesterol, and other issues [psychosocial] because I've been trained to do that.

> [Because of the rotation] I became more comfortable dealing with patients and understanding what they want and how to deal with their emotions and their needs; and what they expect from physicians, other than being a physician....

These feelings of interactive control, comfort, and confidence repeatedly surfaced during the interviews and can be subsumed under the label of communicative confidence. Communicative confidence developed as a result of the positive patient feedback residents received from using the interviewing skills in general, and the emotion-handling and emotion-seeking skills in particular. In turn, increased confidence levels served to expand the frequency and range of skill used, creating a feedback loop that further bolstered confidence levels.

The total-effect residents reported using the skills in all patient settings: "I don't make a big distinction on where I see the patient in terms of how I handle things. The things that are needed, are needed--whether you are seeing them [patients] in the office or at the bedside." Perhaps, as related earlier, because emotions are "part and parcel of us," they also reported the skills permeate their lives.

> I use it a lot with family members and in situations where I am meeting people for the first time. Usually in family situations I use

> it if there is an argument brewing; other situations I just use it in general to continue a conversation perhaps....Meeting somebody and finding something to talk about was always a problem for me.
>
> After this particular class [the rotation], I was able to use things like silence, reaffirming what they have said, repeating what they have said, talking about what you see in your environment and using that to continue on the conversation.

The residents' confidence carried the range of their skill use beyond the confines of their own patients and friends and family to patients of other physicians. Several residents volunteered that they notice when others fail to be patient-centered, and that often prompts them to take action. One resident commented on some senior residents, who although trained in psychosocial medicine, did not use the interviewing techniques: "I couldn't stand working with them because they would go down to the ER and completely muddle up the situation before you got down there." The resident was referring to inaccurate information that was obtained because of the way the data were gathered; the implication here is that in talking with those patients or their families, essentially reinterviewing the patient, he discovered misinformation.

Of equal interest were residents' reported reactions to being physically present when physicians were ignoring patient cues. Often the situations described involved hospital rounds with an attending physician. More than one resident talked about how uncomfortable it was for them and said that if they could diplomatically intervene, they did. If not, they tried to return to the patient later.

> We are doing rounds and I have an attending who doesn't use the elements...the attending is in control...[and] our time is very limited. I can clearly see there is some discomfort there--the patient wants to say something and we walk out. There have been times when I have been extremely uncomfortable with those scenarios--uncomfortable enough that I have pressure on my chest. I can imagine what the patient is feeling....I can see that something needed to be done and I can't do it! ....There have been times when things are obviously starting to get that way and if I am not overriding the attending, I am able to say a statement or two and calm them [the patient] down. What I usually do is I tap the bed as I'm walking out, and I say, "I'll be back; we'll talk again." And I do go back and I say, "When Doctor So and So was here, we were talking about a couple of things and you looked like you weren't sure about what we were talking about, is there anything that I can answer for you? Tell me a little bit about how you feel about what we talked about." And I let them unload....They don't have questions about what is going on [medically]. They are angry, or they are fearful, or they are scared. And it's all these emotions they have to tell.

It takes great confidence to confront patients' emotions in situations where there is no long-established relationship--confidence both in one's own ability to deploy the emotion-handling skills, and confidence that using the skills will evoke the desired response. The total-effect groups' high level of communicative confidence reflects both the degree that patient-centered skills are integrated into their medical practices, and their positive

experiences using the skills. Through their experiences, they have discovered that not only are they more comfortable, but also their patients are more comfortable, and that the doctor-patient relationship flourishes.

Enhancing the doctor-patient relationship. Patient-centered techniques create an environment in which patients can initiate topics, present their agendas, and cue the physician to underlying issues that may need to be explored. Emotion-seeking and emotion-handling skills are tools for that exploration. Smith (1996) posited that emotions are a basic form of communication and that addressing them "leads to the strongest possible doctor-patient relationship" (p.17). Residents' reports were consistent with that position. Their metaphors capture images of building relationships, removing obstacles. Residents commented that emotion-handling skills are a "bridge" that "makes people feel more comfortable," and that in using them "you open doors that you wouldn't have opened up." Another noted that when they are not used, "an immediate wall goes up" because the patient thinks, "He's not hearing me; he doesn't know what's going on here."

According to the total-effect residents, increased communicative confidence in addressing emotional and psychosocial issues of patients produces additional benefits for both physicians and patients. It is a crucial element in the development and maintenance of the doctor-patient relationship because confidence enhances effective use of the techniques which, in turn, fosters the patient's confidence in the physician:

> I tend to think that it [patient-centered skills] is a comforting thing to patients. The analogy is you're in a plane and somebody is piloting it and it's not you, but the pilot has your best interest at

> heart and the patients feel, "This is a real professional. He knows how to handle my [emotional] pain and is not uncomfortable with it; maybe he is going to help me."

Residents also attributed increased patient satisfaction and compliance to effective use of the skills because they sense that patients feel the physician has "more of an insight into what is happening to me."

> I think from the patient's perspective it [patient-centered medicine] improves their satisfaction. At least with me I know there are a lot of my patients who are appreciative of the care that I give them. You know I don't think it is a matter of quality of medical care--that's not any different from other people, but I guess these techniques are helping to deliver what I wanted for these patients.

> I think patients really feel I care about them. I have a very high return rate.

> It [the training] has helped me express myself better to the patient, how I feel about his illness and that has helped the patient, and has helped me improve our relationship.

There are several reciprocal processes at play. As physicians use patient-centered skills, patients disclose more and become more confident in their physician's interest in them. Patients are appreciative, satisfied, and compliant. In return, positive results and feedback from patients increases physician communicative confidence and contributes to other physician outcomes.

Physician outcomes. As previously discussed, on a pragmatic level residents indicated more satisfaction with the quality of information they get from their patients and the efficiency that comes not only from the time-management skills discussed earlier, but also from obtaining all the relevant information from the outset. Of equal importance, were the satisfied feelings residents expressed about themselves in general, "It has made me a better person, a better listener, a more sensitive person," and their work with their patients. A recurring message in the interviews with the total-effect group was that patient-centered work with patients made them feel good, too.

> It [elements of the training] makes it fun to interview. [You] sit down, introduce yourself, and just let them [patients] talk. And I really find that not only is it informational, but it is also fun. I mean you're meeting somebody and you've got a license to meet them in a very direct, in-depth manner; and they are there for your help and that's kind of nice.

> You know there is always that rewarding feeling when you have helped them...maybe you made a difference.

> ...then, you know, it's greatly rewarding to have somebody come into the emergency room and feel like you're the best person they have ever seen in medicine--and they'll tell you that: "You're the only person who has ever listened to me." I've heard that a dozen times.

> ... paying more attention to their feelings and what their illness means to them...patients seem to be more appreciative of being treated more like a person instead of like a patient....It feels goods to me because to me the biggest reward is to get some thanks or good feelings from the patient, to know that you are helping them or doing some good.

Inextricably tied to the "good feelings" these residents get from interacting with patients is their concept of their mission as physicians. They were very explicit in defining helping patients as their primary role. Although one might expect this to be a universal objective among physicians, this notion was expressed exclusively by members of the total-effect group. Helping patients was what they said they liked best about their work and help meant care of the "whole" patient.

> Why internal medicine?...because I like dealing with people; I like dealing with the overall patient. I want to be able to deal with their emotions, their cellulitis, their chest pains...As difficult as it is, as sometimes frustrating as it can be, I don't think I would want it any other way.

> People come to you because they are painful. They come to you because they don't like something about themselves, or that they are concerned about something. And you have the opportunity to be able to help get rid of what may be life threatening or may be socially embarassing or whatever and make them feel much better about themselves.

Embedded in several statements, along with mention of the

gratifying aspects of patient-centered medicine, was the acknowledgement that dealing with the whole patient is demanding and that primary care is stressful.

> I like being down there in it and talking with people. Feeling what they feel, helping them on a real level..... [But the hardest part] The feeling that you can never be completely knowledgeable about everything....'cause you're kind of the front line. The responsibility of that is a strain. But so far it hasn't been enough to offset the rewards you get from being a part of people's lives on an intimate basis.

> I like to be able to deal with the whole patient. And though it's harder, definitely it's harder. I like it better.

The cumulative evidence indicates that psychosocial training helped these residents to work with patients in a way that increased their sense of personal accomplishment and their effectiveness in delivering patient care in the desired manner. Furthermore, their use of patient-centered skills appears to have mitigated some of the more stressful aspects of primary care. It should come as no surprise that goal clarification was another outcome connected to the psychosocial training. For several residents, becoming more confident interacting with patients and the rewards inherent in those interactions were critical factors in their decisions to continue in primary care. A resident who, after one year of internal medicine, pursued and completed a specialty that has little patient interaction returned to complete his primary care residency because he missed patient contact and using psychosocial skills.

> I'm really good at [specialty]; I know I am, but I don't like it--I mean, I'm not dealing with people. Before I had the psychosocial training, I don't think I was as comfortable dealing with patients and I don't think it [primary care] was as rewarding because of that. Once it [working with patients] became more comfortable and you realized that the training actually made you a much better doctor, it was rewarding....

For some residents, decisions to stay in primary care or intensive patient contact specialties such as oncology or nephrology predated the training. In those cases, the training reaffirmed career choices. They acknowledged that it helped them deal with patients better, particularly difficult patients. Regardless of its origin, the process of gaining communicative confidence with patients and deriving pleasure from those interactions--a process that may have begun late in medical school and was further reinforced during residency--appeared to be a significant factor in their career choices. One resident in this category described the changes in her medical interests:

> I was actually going to go into [a low patient contact specialty] when I was in medical school because I didn't think I was good with people. I had a hard time being able to communicate and talk...I was very introverted. I've gradually been able to change that aspect of me and that's why I changed fields....when I was in medical school I thought, "I'm going into [specialty] because I don't have to deal with people and still get to do a lot of good medicine." I was afraid to deal with people, but once I started, I got more comfortable with it.... that's what I like best...being able

> to interact and know that something that you've done or provided for them was helpful....

In this case the psychosocial training did not directly influence the career choice. Instead, this resident's confidence was enhanced by learning specific skills that had not been previously developed; e.g., working with somatizing patients; increasing ability to seek emotions. For other residents, the training itself was a determining factor:

> I'm not really excited now about going into a more technical specialty. I guess it has changed my views or my way of deriving some feeling of being accomplished. A primary care doc has to deal with a lot of psychosocial issues, and for me knowing how to deal with this more effectively and more comfortably has made me feel more comfortable going into primary care, has made me feel easier that I can help them or handle the situation better.

Expressing a similar theme, another resident talked about the influence of the total experience of the internal medicine residency program citing communication skills as the most helpful aspect.

> But more and more I sit and think about wanting to do different things and I wonder whether or not that is because I trained here....I look at wanting to make a difference at a primary care level and that's a strength of this program--we stress primary training. Just the fact that I think about it, that's probably a direct benefit of my training here....I think it all boils down to better communication really. If you think about it, the scientific knowledge has always been there. People have always had scientific know-how, but learning to communicate better hasn't

always been stressed. Certainly not in medical training until recently. So the communication skills is the one big benefit of the [residency] training.

As evidenced by the excerpts from the total-effect group's interviews, these residents share a common vision of delivering care to patients. With remarkably similar and/or complementary descriptions, they vividly detailed working with patients, picking up patient cues, seeking emotions, and using a broad range of skills in a broad range of settings. Members talked about their confidence and satisfaction in treating the whole patient and the benefits of patient-centered medicine for both their patients and themselves. They talked about the relationship of feeling communicatively confident and selecting primary care and high patient contact specialties. In addition to these elements, woven throughout their talk, is an aspect of introspection--an acknowledgment of how their own personalities and emotional responses contribute to the successes and sometimes failures of communicating and helping patients. This key element, self-awareness, is necessary to enhance the doctor-patient relationship and deliver patient-centered care. Evidence of its active presence was prevalent in the total-effect interviews.

Self-awareness

As was discussed earlier in chapter two, physicians' abilities to recognize their own feelings and attitudes, and to address and modify unproductive personal responses that compromise patient care, are critical to developing therapeutic doctor-patient relationships. In essence, optimal understanding of others requires understanding of oneself. The ability of the total-effect group to explore patients' emotional issues was enhanced by

their own introspection and self-awareness process. Process is the operative term. Self-awareness is not something that is acquired once and then remains static. Self-awareness evolves. Among total-effect residents, evidence of self-awareness training manifested itself in a variety of ways. They talked about reacting to their patients and looking inwardly when communication with patients doesn't go well:

> When you can tell that your attitude toward a patient is changing, when you know that something is not right...put it in the back of your mind to think about--that is something that was brought up in the rotation that was helpful.

> If you have a [relationship] with a patient that is not comfortable and what you are doing doesn't seem to be working, then that's one of the things that you step back and say, "Well, am I really listening to this patient?" Are we getting out of the sessions or the visits what I want to get out and what the patient is expecting, what the patient wants? And sometimes you need to regroup and look at that ....

Total-effect residents also talked directly about the importance of self-awareness work during the psychosocial training and its impact, sometimes with specific reference to their patients and themselves.

> I think when I started out with the program I wasn't aware of, shall I say, the limitations that I have myself; you know like my own personality. There was so much I was aware of at the end of the program.

Before the rotation, I didn't realize how [my feelings about a specific issue] would affect how I dealt with patients. After the rotation, I realized it would...which was very important because I had one patient where that one feeling in particular could very much affect how I dealt with that patient; I made my behavior a little different by recognizing that I had a biased thought about this particular patient.

I think before the rotation I felt, "Man! I must be a real bad physician because my patients are always angry."It [the training] kind of brought out to me that maybe I'm insecure about myself in a way. Since that time things have improved remarkably. I have been able to deal with patients who obviously are not pleased, but I realize that it's not because of me. I mean, life has dealt them some very difficult blows, and I think if I had been dealt those same blows, I wouldn't be pleased [either]. [The rotation] has helped me to solidify my approach on how I deal with those things.

[During the training] It was difficult looking at the fact that I wasn't always particularly great at emotion handling and active listening. There were times when a patient would go off, take a different string, and I might have tried to redirect the patient back to what I thought was important. It was difficult to come to the point where I could employ all the techniques and do a good job. I

> guess I'm still not sure how good a job I do. I make the effort and I think as time goes on, I'll get better.

This last excerpt touches on yet another recurring theme indicative of self-awareness and personal growth--the notion that mastering communication with patients is an ongoing process. Many residents mentioned the need to continually work on their skills and self-awareness.

> I think personally I would need more training in learning to identify my feelings and not letting them interfere with the relationship...especially in those situations in which I feel I am being manipulated; that generates a lot of anger in me.

> I think the level at which I listen to patients is better now than it was. [Before training] I thought I was doing a fair job of listening to patients. And I had a lot to learn. I wasn't as far down the road as I thought I was. And that [the training] sort of opened my eyes and now I sort of accept that....If we think we are doing a good job, we probably ought to step back and take a look.... You don't have to beat yourself up, but you need to be aware that there is always probably room for improvement. Step back, take a look to see if you are really where you think you are. If not, work on it.

In what appears to be a somewhat parallel process of self-discovery and development of appreciation of the training, residents also talked about their evolving perceptions of the psychosocial rotation in conjunction with their talk about self-awareness. As in the previous

example, for some residents appreciation of the training developed more over time:

> My initial perception of the training was a little confused...not really sure what I was dealing with. My perception now is that it has been invaluable.
>
> ...from going in kicking and screaming as I mentioned before, to coming out of it thinking, "Maybe they have a point." Then you [begin to] use it and you *do* get better information out of it and it kind of validated what we learned that month.

For other residents, it was clear that appreciation and self-awareness were present to some degree during the four-week rotation. One resident recalled a specific incident that had occurred during a role-playing session two years before. Although its value is occasionally appreciated in hindsight, role playing is not generally a popular technique with residents and participation is often met with some resistance. In this case, however, the resident had a powerful experience and recognized the value of the both the technique and the experience immediately.

> We were doing something and we had to stop. I think my partner had had a loss at one point so this [role play] was touching her chords somewhere in there. And it was touching mine from some...experience I had had with my daughter. We started getting too sensitive. It was a big time out--it was because we got as far as it was okay to get. Don't get me wrong, we weren't upset about this; it was like, "*Wait, wait...we've got to stop, back up now and kind of go over this.*" *It was very instructive*

because I think from that point on I realized that I'm not the only one who has emotional baggage--That my patients could also have some things--a hidden agenda in there. And it's okay for me to let a little bit of myself be exposed to the patient because how can I expect them to expose themselves totally without feeling some kind of bond there? We talked about that and opening up in front of people and that is what I learned.

This same resident also valued rounds with the faculty and with keen observation, took what was needed for her personal use.

> [Watching the faculty demonstrate interviewing techniques] was most helpful and most important... When we would go to the hospital and he would show us what to do.... I don't think you could ever get tired of seeing [him] doing that. You can understand things....And that was very important because every time I saw, I was able to take a little bit and build on what I was doing. It's still hard for me to designate where a problem might be, a stumbling block. But all of a sudden, I would recognize it in his interview and say, "Okay, now I have something else I can do." It was like I found a piece of the puzzle.

The psychosocial training provided many puzzle pieces for these residents. The total-effect group put the pieces together to form a cohesive picture of patient-centered medicine. They appeared to be in a continual state of self-appraisal. Self-awareness and other-awareness permeated discussions of their medical practices. Their interest in and ability to self-assess is perhaps <u>the</u> essential contributing factor to most improving their patient-centered practices. It is the precursor to their understanding the

reciprocal nature of communication, their communicative confidence, their broad and effective use of the interviewing skills, their ability to develop positive relationships with their patients, and the positive outcomes that result from those relationships. To the extent that self-awareness is underdeveloped, physicians' private issues and emotions will erect barriers preventing them from interacting and using interviewing skills effectively. Instead of seeking emotions, emotions will be avoided; instead of eliciting the patients' stories, patients will be interrupted, topics shifted, and attention will focus more on the biomedical aspects of medical care or other topics of the doctor's choice. Exploration of these topics continues in the sections that follow describing the remaining nine residents for whom psychosocial training had partial or minimal impact. Each impact cluster is necessarily small in number. Nonetheless, the clusters had distinguishing features that differentiate them from each other and striking similarities within them that bind the individuals together. The minimal-effect group provides the most pronounced counterpoint to the total-effect residents and is presented next for that reason.

The Minimal-Effect Group

A resident described working with patients' personal problems and talked about the types of problems addressed:

> There's a lot of social issues that we deal with. Frequently, in the hospital, it tends to be where is the patient going to go after they get out. They tend to go back to where they came from which is typically from home as they were, or home with assistance, or do they have to go somewhere else like adult foster care or a nursing home? So we frequently deal with

problems which often involve the patient's whole life...what resources they have; who lives with them....On the clinic level, it tends to be more the psychosocial, somatization type of thing--chronic headaches, abdominal pain--panic disorder.... I feel better about panic disorder [than somatization cases] because a lot of them do better once you make the diagnosis and you put them on the right medications.

Interviewer: Is there anything in your experience that has helped you to deal with patients' personal problems?

Well, I think the thing that helps the most in many cases is having a good social worker....

In contrast to the total-effect group, this resident from the minimal-effect group described dealing with patients' personal problems in terms of the logistics of getting patients home from the hospital, in treating panic disorder with medications, and in "having a good social worker." There is nothing inherently incorrect with these responses. In fact, it is unlikely that total-effect residents would disagree. What differs from the total-effect group is the absence in the narrative of personal descriptives, of a sense of patients-as-partners, and of the belief that quality patient care exceeds treatment of physical symptoms. The minimal-effect group is characterized by a more biomedical orientation to patient care and a search for linear solutions to observed problems. For them, enjoyment of

working with patients appeared to be greatly diminished if physical improvement and management were unlikely or difficult, or if on-going attention to psychosocial issues were required. Representative of this group is a resident's description of the patients she works best with--the ones who will be the hardest to say goodbye to at the end of residency:

> I guess the ones I have the best relationship with are the ones that have actual organic disease.... The ones that are somatizers have gone by the wayside--I haven't actually seen them for the whole three years. The ones I actually had for the whole three years are the ones who have real, live, kind of serious to half serious disease who come in fairly regularly for intensive medical care....

It is noteworthy that the "somatizers have gone by the wayside." As was discussed earlier, working with somatizing patients is perhaps the most stringent test of patient-centered skills. They often require more time initially, and more frequent visits. Success in improving their well-being has been shown to be related to strong doctor-patient relationships that develop through use of patient-centered techniques. The absence of these patients from a primary care practice suggests that the doctor-patient relationship cannot fully develop or that the doctor is disinterested.

Using Interviewing Skills

Consistent with the previous example, and an implied preference for the biomedical model, the minimal-effect group did not indicate profuse and integrative use of patient-centered skills. Their accounts of work with

patients lacked descriptive detail. Perhaps because the skills are less critical to the acccomplishment of their primary goals with patients, skill use is not as salient as with the total-effect group. For example, one resident described using interviewing skills as follows: "I do try to spend--I'm not sure how many minutes, but the first several questions anyway, just letting the patient ramble on about whatever they want to talk about.... I really try to focus on the history more than physical." In this context, the latter comment implies that gathering history data is the same as being patient-centered. Weston and Brown (1995) noted it is not uncommon that young doctors concentrate on history taking instead of interviewing--mistaking a "psychosocial functional inquiry (p.139)" with being patient-centered.

In response to inquiries about the influence of the training on their work, the minimal-effect residents were more likely to make either general, but somewhat qualified, statements about the rotation's enhancement of humanism in medicine, or comments that the rotation had only reinforced what they already knew.

> The only positive and memorable thing I had from that rotation just tells you not to be a robot--have human feelings and keep in mind the person you are treating is a human being.

> I think that the material is largely intuitive and four to six hours of training would be reasonable.... It seems to me that I have had unending training prior to being here.... There is nothing in the training that I haven't done many times before.

> I don't think there was anything that was presented in a new

> fashion or something that I had never seen before.... but it was a good review...it helps to facilitate patient-physician interaction. I mean it just makes you more humanistic, so it's important.

> ...when I went through it there wasn't enough information to spend four weeks.... I'm not exactly sure when I started [using open-ended questions]. I think you're taught that way so you are always kind of doing it--any kind of physical diagnosis text book or physical diagnosis class in medical school--that is how they would teach you to do it.

None of these residents mentioned <u>seeking</u> patients' emotions. Attesting to some positive impact of the psychosocial training, they did talk favorably about the value of emotion-handling skills, e.g., "NURS was a good technique." When minimal-effect group members talked about using the emotion-handling skills, it was in the context of patients explicitly indicating their need for them. One resident specifically said that he used them when patients were in "distress." Indeed, unlike the total-effect group who used patient-centered techniques broadly both to elicit and respond to patients' emotions, the minimal-effect residents appeared to have specific times and places in which they considered them appropriate.

> I use the the interviewing skills--the open-ended kinds of stuff--I use that all the time, at least in the clinic. ...and I use the the emotion-handling skills--that tends to be more in the hospital. Just today, for example, there was a woman who has metastatic cancer and she was angry and depressed and afraid and all those kinds of things and...I asked how she was and she said, "I'm

> depressed and tired".... [she was] crying out for someone to say, "Oh, you must be very afraid, you must be...whatever."

The resident had been in a hurry, but in this case the patient's anguish demanded attention. Usually, when time is an issue, emotion-handling and other interviewing skills are set aside.

> I tend not to use [interviewing skills] when I'm in a hurry, or if I want to just cut to the chase and move on. So like in [a routine] emergency room interview, I never ask an open-ended question and I never use emotion-handling skills in there. I have ten questions and I want a yes or no because I got to get out of there 'cause I have got to get out of there 'cause I have seven other patients to see and it's three in the morning.

It was not just in the emergency room, though, where this resident felt rushed. In spite of the admission that, "you get better information with emotion-handling skills and open-ended questions....," in this group, residents mentioned that time pressures and being busy often precluded their use of skills. The perception of "busy" is an interesting and personal phenonmenon. Although the patient load and residency requirements did not differ among the groups of residents, the minimal-effect group appeared to feel more pressure. For some, patient-centered medicine seemed to be contingent on resident's schedule, not on the patients' needs.

> [Outpatients] are pretty understanding--I guess in a bad way--about my schedule. Some of them realize when I'm running busy and we just kind of get right to it.... sometimes I want their input and sometimes I don't depending on what time of night it is and

how busy I am....

> I know why its [the psychosocial training] there for us to develop humanistically, but all the different pressures we go under--I know for myself that my tolerance for extraneous details has decreased.... Sometimes I feel that I'm really rude to patients because I don't have time to sit there and talk about a lot of their emotional problems. I've gotta take care of other things, and if I don't take care of those things it doesn't really matter what the emotional problems are because these people are going to get sicker.

Lack of Self-Awareness

One explanation for the avoidance of skill use, other than the time constraints mentioned, is the presence of unrecognized or incompletely recognized feelings on the part the residents about exploring emotions in general--both their own and others'. Every member of this group indicated some discomfort with, or dislike of, dealing with emotions. None acknowledged the impact such discomfort might have in developing relationships with patients (e.g., in the case of the resident whose somatizers had gone by the wayside) nor a need to work on those issues. Evidence of self-awareness in this area was minimal.

"Running late" with patients is a well-recognized, potentially harmful behavior that masks unrecognized feelings of doctors (Stewart, Brown, & McWhinney, 1995) such as a need to control. As Weston and Brown (1995) noted, "The most common excuse given to avoid asking about patients' personal concerns is lack of time. But it is not an efficient

use of time to search for a disease that is not present or to ignore a major source of patients' distress, such as their fears or concerns" (p.139). Weston and Brown also remarked that new doctors need practice to feel comfortable inquiring about patients' personal lives.

The psychosocial rotation emphasized the application of skills by providing a variety of opportunities to practice and receive feedback on interviewing techniques including: group continuity rounds during which faculty and residents conducted interviews with hospital patients, role play interviews between residents during seminar sessions, and tape reviews of interviews that residents conducted and recorded independently. Residents from all three groups acknowledged growing weary of one form of practice or another during the rotation. However, in contrast to the total-effect group who came to appreciate various training elements over time, the minimal effect group remained quite critical of the training two years later. As one resident put it, "I went in kind of dreading it, and came out thinking I was right."

Critiquing the training. As was illustrated in previous quotations, this group of residents felt strongly that the rotation should have been shorter because there was not enough new material to warrant four weeks. In sharp contrast to the total-effect residents, some group members stated that the training was just not practical: "...no matter what your agenda is, theirs [the patients'] is more important.... In theory a lot of it is great, but in practicality it's hard to institute." In addition, training methods such as tape reviews of patient interviews were also characterized as "theoretical."

Embedded in other group members' conversations about the training were comments about hating role playing because it felt like "I was in group

therapy; I really hated it--I hate group therapy; I had no interest in doing it." A further illustration of persistent criticism of the training is embodied in this excerpt from a resident who found the training too long and too easy:

> ...the most challenging part [of the training] is trying to be sincere enough about it that you don't insult the people trying to teach you because certainly some of the other residents that you're on the rotation with have a poor attitude about the rotation and the material and all that. You are asked to act or pretend you are a certain kind of patient--it's challenging to try to keep a straight face.... I think it [role playing] is useful to a point; we did a lot of I think after a certain point, you don't get a lot out of it. The preceptors are trying to have a serious discussion and you're just not getting very much out of it.... You feel like you're *wasting your time.*

It is impossible to judge whether the issue of time surfaced again here due to unconscious, internal discomfort with the course content or methods; e.g., practicing emotion-handling skills during role-playing. However, this resident commented about feeling "manipulative" when interviewing patients during continuity rounds because "we didn't have any participation in their care--their *real care.*" Interestingly, this was the only resident who mentioned using emotion-handling skills outside of the medical environment, but the resident felt manipulative about that as well:

> Well, you catch yourself doing the NURS stuff with *real live people*...you catch yourself, and you're kind of amused ...you're talking to [someone who is angry] and you'll say, "Boy, you sound really angry...." And it makes me feel subtlely manipulative

> when I'm doing this. Then I say, "Boy, I really sound like a psychologist there"...you wind up sounding outside the hospital like you do when you're in the hospital; makes you wonder where the separation is....

The distinction for this resident between patients and "real live people" as well as the preference for partitioning communication skills may indicate that the resident is still in the distancing phase of the medical socialization process. Ironically, the same resident commented, "[I]...wouldn't mind spending more time doing it [psychosocial training] now [in the third year of residency]--I would mind four weeks; I don't think I could do four weeks." Moreover, in another part of the interview some positive outcomes of using patient-centered skills were mentioned, "I think the more time you spend doing those kinds of things, the more aware you are of different kinds of patients and how you react. It makes you more aware of your own feelings." These apparent contradictions are difficult to interpret. It may be breaking up the training would make it less monotonous. Alternatively, it is possible, based on previous comments, that the intensity of the interviewing would be easier to handle in smaller doses.

Unlike the total-effect residents who viewed emotion-handling techniques as universal communication skills, it appears that for at least some in this group, that emotional talk is tantamount to psychoanalytical talk--unessential for medical treatment (real care) of patients and not totally appropriate, perhaps too personal or too intrusive, for conversation even with friends and family.

Outcomes of the Training

In spite of the criticism and the apparent internal discomfort with aspects of the training, there was acknowledgement that patients "tend to respond very positively" when emotion-handling skills are used and that their use "makes me feel better about what I am doing." One resident when asked how he would feel if he were unable to use the skills, responded, "More uncomfortable and you would have less of a rapport with patients--understand what they are going through less than you do." He later added that the rotation helped him to be "more comfortable dealing with the so-called difficult patients." These comments are as close as any member of the minimal-effect group came to expressing communicative confidence as was defined in the total-effect section. The level of confidence expressed in the minimal-effect group is consistent with the degree of skill use indicated.

Goal clarification. In spite of the small number in this group, two of the residents indicated that the rotation had helped them to clarify goals.

> I think the one thing is that the residency, and maybe the [psychosocial] training, has helped me to identify what I do wrong. What I do know is that...I deal with miserable situations well. I'm comfortable with them. I found through residency that I enjoy dealing with very difficult problems of people who are very, very ill.

> From day one, I was flirting with doing a surgery subspecialty, or surgery, or something like that. I'm happy I got the training, but I don't really see myself in primary care--but I think the training has helped me to realize that, and I'm thankful for it.

Discovering one's strengths and weaknesses is part of the self-awareness process. The recognition by these residents of their preference for, and skill with, the biomedical model may be a beginning of self-knowledge. Nonetheless, it is clear that the training had little impact on this group of residents' work with patients or on their career choices. It reinforced notions of humanism in medicine, served as a review of skills perceived as already known, and may have added a few techniques to their repertoires. There is little evidence of integrated use of patient-centered skills in their descriptions of working with patients, virtually no talk of expanding their communicative confidence, little evidence of self-exploration relative to work with patients, and little talk of the impact of skill use on their patients, their relationships with them, or on themselves.

In the next section, the impact of the training on the partial-effect group is explored. Mid-way between the total and minimal-effect groups, partial-effect residents are characterized by ambivalence. They demonstrated knowledge and application of skills, and simultaneously, a limited (though more extensive than the minimal-effect group) use of them. They talked of wanting to be supportive, and simultaneously, of finding it hard to listen to patients' problems for too long. They expressed genuine appreciation for the psychosocial rotation, but remained critical of the training as well.

The Partial-Effect Group

A resident described working with patients' personal problems:

> I have...a lot of patients with psychosocial problems, but I think most of them had so many problems that at times, or actually most of the time, I could not handle. I was trying to be

> supportive as I could and once in a while I took my time and asked them and tried to be understanding and learn a little more about what was bothering them. You know like people were going through divorce...a few of them had money problems...a few had legal problems. And you know I really couldn't give them as much attention as maybe I should. But most of the times, I had fifteen minutes with them and you do feel that you need to focus on medical things, too. You really feel like you can't spend that much time listening to their problems because ultimately there is not much I can do anyway. So I just try to figure out a little bit about what is going on and hook them up with a social worker who would help them a little bit more. And through the social worker I get a little more information--sometimes things I didn't know about would come to the surface....But it [the psychosocial training] did help me. I mean, I remember at times to say [to myself], "Okay now, I better shut up and listen to what they have to say." And I don't jump to conclusions right away. It helped with things like smoking and cholesterol....

This description is representative of the partial-effect residents in several ways. It captures their appreciation of the training and their concern for patients beyond a medical diagnosis. It also captures their attention to some patient-centered techniques and their feelings of being overwhelmed by psychosocial problems. In contrast to the earlier excerpt from a total-effect resident who personally uncovered information from his patient and subsequently referred the patient and her mother to a social worker, this resident relied on social workers to glean psychosocial information about her

patients and filter it back to her. For her, similar to the minimal-effect residents, a little distance was more comfortable.

Intergration and Value of the Psychosocial Training

Compared to the minimal-effect group, the most distinguishing feature of the partial-effect residents was the unequivocal value they placed on the training. None in this group indicated a predisposition to patient-centered medicine, instead they credited the rotation in helping them to understand and think about patients in ways they had not done before. Similar to the "aha" residents in the total-effect group, learning and applying the biopsychosocial model added a new dimension to their medical practices that was very much appreciated. Also like the "aha" total-effect subgroup, all of the residents in the partial-effect group were born outside the United States. Even though two of the residents had attended a psychosocially-oriented American medical school, they, too, credited the psychosocial rotation with changing their perspectives.

> Before the rotation, my insight into patient problems was not there, was not that much at all--personal problems at home or what they come to the doctor for--underlying depression or sadness or things like that. Another aspect is somatization....I met people like that before the rotation and I didn't realize it.

> It opened insight into the patients and interviewing.

> [Before the rotation] I didn't have good insight [into patients' feelings], and I think the rotation helped.

> I think it [the psychosocial rotation] was a good idea. It helped me....it made it easier to deal with a patient. Like maybe in the past, the difficult patients were always bothersome; now they might be a challenge or might be more interesting.... The other rotations [e.g., hospital rotations, biomedical rotations] weren't anything I was not getting in the past, but I think the psychosocial service was something new.

Communicative confidence. Residents in this group did not explicitly talk about feeling more confident in communicating with patients as a result of the training. Instead, increased confidence is implied in their talk of how the training generally helped them, how it helped them to deal with difficult patients, and how it expanded their abilities to explore depression and stressors that may contribute to physical symptoms. Prior to training, this group had not given much consideration to treatment of patients beyond their biological symptoms. Depression, somatization, and the impact of social and psychological pressures on physical health had not been salient in their notions of medical practice. The training added new diagnostic and communicative tools to their repertoire. Group members indicated use of facilitative skills such as silence and open-ended questions, "Tell me what's happened?...What's going on?" They were somewhat more detailed in their examples of working with patients than the minimal-effect group, but not nearly as expansive as the total-effect residents.

Outcomes of skill use. With less enthusiasm than the total-effect group, but more than minimal-effect group, patient-centered skills, particularly emotion-handling skills, were considered useful and beneficial to the doctor-patient relationship. In addition, although not nearly as explicit or

prevalent as in the total-effect group, there was some evidence of seeking emotions as well as responding to them.

> After the training, we [residents] start paying more attention to the psychosocial aspect, like is the patient depressed? Plus getting the patient's understanding of the problem mainly and being a little more aggressive in naming his problem...and see how much emotion he hides behind his organic illness. We learned the NURS scale about naming his emotion and handling it. This was really good.... A lot of patients feel more comfortable with the physician after this. Like "the physician knows that I'm sad." You show them that you understand their situation and you try to support them a little bit. This makes the relationship somewhat closer.

> [The training] gives you an idea or maybe a skill of how to deal with people in difficult situations. Sometimes in the past you might have thought some situations are impossible...now you can turn it around.

> The patient is in the room and you say, "You don't look too good today." And then they will open up and tell me what is going on. And a lot of times you use these skills that we are trained in unconsciously. The NURS thing...I use it a lot. Sometimes I [say], "Wow, I can see how you feel that--it must be hard," and things like that.

As with the reports from the total-effect group, residents noted the positive effects of using the skills for their patients and themselves.

> They [patients] love me!.... It feels good, you know...that they [the patients] like you.... You hear it from the nurses or from the receptionists. They [the patients] tell them, "he's nice, he's caring, he's thorough."

> [Using skills has affected my practice] by improving the physician-patient relationship and compliance.

> What it does is help you provide better care for the patient and have a good, better, relationship with them.

Working with somatizing patients. Partial-effect residents responded to the somatizing patient scenario by accurately outlining elements of the somatization model as they described how they would proceed with the patient. They provided more detail than the minimal-effect residents and included explanations of the role stress plays in inducing symptoms, the need to reduce narcotics and tranquilizers, the importance of gathering psychosocial data from the patient, and and the importance of scheduling the patient for frequent visits. Unlike the minimal-effect group, partial-effect residents retained their somatizing patients in their outpatient clinics, but expressed significantly more frustration with them than the total-effect group.

> I sometimes feel pity for them [somatizers] if they do have a very stressful life and everything. But I don't...I guess I even hate them if they are not willing to do anything. Sometimes, you

know, people are so reluctant to change, take advice and stuff like that. And I don't even understand what they want from us.

[It's] very hard, very hard [to work with somatizing patients]. To be honest with you, it is hard in our medical clinical setting to deal with that because we don't have much time...because you need more time to deal with it or more visits--more frequently.

Scope of skill use. The mention by several group members of positive outcomes from using skills implies a higher degree of implementation than the minimal-effect group. Nonetheless, like their minimal-effect colleagues, they restricted the use of these skills in various ways. One resident said he used patient-centered skills more on an inpatient basis than outpatient; with another resident, it was the reverse. Some mention of time constraints emerged, but not with the intensity of the minimal-effect residents. For example, in the opening quotation for this group, the resident said that in fifteen minute appointments it is sometimes hard to attend to psychosocial problems to the extent she would like, and in the previous excerpt, the resident mentioned that time was an issue working with somatizers. Others in this group also mentioned that time issues sometimes hinder them from using skills, but in general, they tried to incorporate the skills all the time:

It's not a switch that you switch on and off. It's just in your system, you keep using it with every patient the way its required for that patient.

Statements describing skill use as "always there", or that skills are used "unconsciously," or that they are "second nature" permeated the partial-effect group's interviews. Although total-effect residents sometimes

used similar phrases, their descriptions of working with patients illustrated precisely what had become second nature to them. In contrast, the partial-effect group was less specific about how and what they actually had integrated into their practices.

There was little mention of using the skills outside the work environment, but when the subject did surface, the theme of using them "unconsciously" recurred: "Once you believe in something, you incorporate it into your system whether it's a patient, a friend, or any relationship, you kind of use it."

The idea of absorbing the patient-centered techniques and unconsciously applying them was unique to this group. Also unique to the partial-effect residents were their reactions to and descriptions of the learning process.

Reactions to the Training

As a group, the partial-effect residents had a distinctive cognitive-learning orientation. This is particularly noteworthy in the context of their overall favorable reaction to psychosocial medicine and the training in general. These residents were more likely to mention enjoying lectures and the somatization and patient education models--often expressing a preference for structure and more passive observation over actual practice of interviewing during rounds. It should come as no surprise that their discussion emphasized thinking and reading about psychosocial issues.

> ...It's just like reading about myocardial infarction, now you know about myocardial infarction; *reading about this training in psychosocial, now you know about psychosocial.*

> I did enjoy the lectures.... I think that if those were more, it would have been better. I did like to see the *other* people doing the interview....
>
> I think just emphasizing it [psychosocial medicine] and thinking about it [is the most important aspect]. I don't think any specific technique would work. I think I spent that month and I thought about it and it made it important...I think one thing in the program --they were trying to be specific. It didn't work for me. You cannot teach people that's how you ask a question....I didn't like it because I didn't think somebody can tell you, "I always ask this question first." ...I think the most important part [of the training] was that *I never thought* about this thing in the past....but if I have to name one rotation that helped me overall, that helped me more than others, I would say that it was the psychosocial rotation *because I would have never become familiar with these issues. I would have never read about it.... I can always read a nephrology book....*

Consistent with the preference for reading and thinking about communication skills, which requires less time than practicing and acquiring them, some partial-effect residents protested the length psychosocial rotation--"two weeks would be good;" "I was wondering if it could be concentrated into two weeks." Contrary to the minimal-effect group, there was no suggestion that the training needed to be shorter because the material was intuitive or redundant. There was, however, a reprise of the minimal-effect group's discomfort of interviewing patients during rounds:

> I think you have to deal with a lot of psychosocial aspects [during

> training]. We listen to information from the patient regarding his family background and their feelings. Sometimes it's hard; it's hard because some of us don't like to do that; I personally didn't like to do that.... It's a hard thing to deal with...you cannot do anything for them, you know. You cannot help them [just] listen and empathize and the suggestions you give them...I don't know if it helps to give suggestions....[Responding to whether the rotation was difficult]...No, it was just a matter of *listening too much* to other people's personal life stories ... That's why I'll never be able to be a psychiatrist or psychologist.

Self-awareness Issues

As was discussed earlier, reactions to and appreciation of the training appear to be tied with the reality of using patient-centered skills and self-awareness processes. Unlike the minimal-effect group, partial-effect residents clearly appreciated the training both at the time, and certainly later in residency, indicating enthusiastically that the training had "helped them." Nonetheless, the distancing accomplished through a cognitive-learning orientation coupled with recommendations for a shorter rotation and less interviewing appear to correspond with avoidance of emotions and psychosocial problems, and are suggestive of unrecognized or incompletely recognized feelings driving the distancing behaviors. Consider the following example.

Related to the issue of having had to "listen too much" during the psychosocial training, a resident recalled a specific incident during the rotation. During interviewing rounds, a faculty member asked the resident

why she had not used emotion-handling skills with a patient:

> I was kind of tired listening to all the depressing things with nothing we could do about it.... At times when I talked with patients, I was not able to give too much of the NURS feedback to the patient. And one of the questions was, "Why didn't you do it?" [My response:] "I just didn't feel like it. I didn't feel inside [like asking] "What is going on with you?"--you know, empathize with what they are going through. I just didn't have anything to tell them. I [have to] have the genuine feeling to ask them why they were having a problem--that's how I approach it. I cannot just say, "You tell me this," and say, " Boy, that is good, or that is sad." I cannot do that. It has to be genuine otherwise it won't be good.
>
> Interviewer: It sounds like you were burned out.
>
> That's right; that's right. That's why I say four weeks is too long. Even if it were my patient, and I know the patient [well], I would have probably reacted.

Indeed, this resident does react the same way to her own patients. In a separate part of the interview, she spoke about using emotion-handling skills with patients, "all the time; all the time," but still it must feel natural: "..not necessarily [thinking], 'I gotta use this,'[more like]... I *feel* that I need to use it; and then I use it."

These comments suggest that she avoids responding to or pursuing emotions when the patient's situation fails to evoke an empathic response

or perhaps when she feels uncomfortable. Although she is aware that she acts only when "it feels genuine," the suggested depression she feels remains unacknowleged and underlies the avoidance behavior. As with members of the minimal effect group, there was no mention in this context that avoiding emotions might impede the development of the doctor-patient relationship, and, largely because it had not been identified as a problem, there was no indication of interest in working on this issue.

Nevertheless, this resident demonstrated some areas of self-awareness as well. In later conversation, self-awareness was acknowledged as an important part of the training and ironically, that feelings determine relationships.

> I think it [self-awareness training] was valuable. How you establish your patient rapport is based on how you feel, how aware you are sometimes. And if you know that the patient does certain things, says certain things that make you angry and you just snap back, you're gone because the patient is gone. And it's hard to live with that. It's important to recognize feelings had how you will respond--it's important for a physician.

Awareness and control of anger in response to patient behaviors appeared to be the focal point of self-insight, and an area that the resident seemed to be working on. For example, she said that angry, demanding patients put her on the defensive and that knowing that about herself is helpful: "That's [patients who are angry or demanding] kind of a red flag telling me to watch myself....I do have a temper episode to sort out. I keep constantly telling myself, 'if something like that happens, cool down.'"

In contrast, some acknowledged problems evoked only a passive

response. When a resident was asked if there was anything she avoided talking about with patients, she readily responded, "sexual histories." In spite of recognizing the avoidance behavior, there was no current interest in correcting it:

> [Sexual histories are difficult for me] because you forget it. That is something I should be incorporating more...I think hopefully now that I will be out there in private practice I will be more confident enough to ask.... I'm aware of some of my weaknesses.

Of the three levels of training influence, the partial-effect group showed the most evidence of an internal struggle to come to terms with what they feel is important to offer patients, and what they personally feel comfortable in delivering. Consequently, as might be expected, there was little indication of the influence of the training on career choices or on goal clarification.

With one resident, however, it was clear that actively dealing with psychosocial issues was a catalyst for the self-examination process. The resident talked about liking to be "happy" with patients and enjoying obstetrics patients in primary care for that reason. The following discussion of the things that are liked most and least about being a physician captures the essence of the resident's internal conflict.

> The thing I enjoy most is that the patients trust me, and they say," I never listened to anybody else before...." Things like that are very rewarding...that is the thing that gets you going. If all these patients appreciate and trust you, you just have to respond to those expectations.... [The least attractive part of being a physician]...having to deal with--everything is kind of your job to

> solve, like psychosocial problems....they are uncomfortable because most of them don't really depend on you. I mean you can make the patient feel a little better, and teach them how to handle things a little better, but ultimately it is their job to take care of their problems.... So I feel that I am put in a situation in which I have to deal with all these things and in fact, I shouldn't. I guess it's sort of like maybe I shouldn't have been [in primary care] and sometimes I feel like that. I'm like, "Oh, I wish I wouldn't have to deal with all of these things." So maybe I'm looking at that I'm not a good physician--I should have been maybe something else. But, I'm learning to deal with it [psychosocial issues], and I'll probably learn to accept the fact that it is part of life and I have to deal with that part, too.... I think the ones that talk to me about their problems feel better because they don't have anyone else to talk to and I can understand that.... But some of them will come to complain about the system [economic needs, housing] and that is something that I don't know how to handle because those problems are not created by the patient. They are so much more difficult to control and I don't know how to handle these things.

There is a passivity and ambivalence toward patient-centered medicine that pervades the partial-effect group. On one hand, they reported positive feedback from patients, enhanced doctor-patient relationships, and good feelings about themselves from using patient-centered skills. Unlike their minimal-effect counterparts, they credited the psychosocial rotation

with improving their understanding of and communication with patients, expanding their notions of medical practice, and increasing their confidence in dealing with difficult patient problems. Although they were far more passive in their pursuit of self-knowledge than the total-effect residents, the beginning of a process of self-examination and initial work on what is discovered was evident with some members of this group. As one resident put it, "I'm not a good doctor yet."

On the other hand, the partial-effect group indicated a uniquely cognitive-learning style and some sustained discomfort with some elements of the training. They had a lower tolerance for discussing and pursuing psychosocial issues than total-effect residents. Relationship-impeding feelings centering around control; i.e, being confronted with problems that they were unable to resolve, surfaced for some, and use of emotion-handling and emotion-seeking skills were limited by residents' discomfort.

All three groups of residents received the same four-week rotation and were influenced by it in varying degrees. The greater the training influence (a combination of using the skills and attributing their use to the training), the more residents reported positive outcomes for themselves, their patients, and their relationships. Using patient-centered skills increased residents' communicative confidence. In turn, bolstered communicative confidence further expanded skill use. At the core of the training influence, however, was self-awareness. Residents' learning how to identify previously unrecognized feelings in themselves and take corrective action was associated with their willingness to overcome their own discomfort, practice the skills during the training, and use them with their patients following it.

Progress with self-awareness is a process that was paralleled in residents' reports of skill use and reactions to the psychosocial rotation. For some members of the total and partial-effect groups, the benefits of psychosocial training were immediate and by all accounts were ongoing; for other members of those groups, the benefits did not have as great an impact immediately, but accumulated over time and appeared to continue. For the minimal-effect group, the benefits recounted were negligible up to this point in time; however, because self-discovery is a process, patient-centered techniques may prove to be more valuable at a later time in their careers. To gain further insight into that possibility and the impact of psychosocial training in established medical practices, additional interviews were conducted with psychosocially-trained practicing physicians. In the section that follows, highlights of those interviews are presented.

Physicians in Practice

Practicing physicians who agreed to interviews had received psychosocial training four to eight years earlier. Consequently, at the time of the interviews their paths had diverged more than those of the residents. The physicians represent specialties of oncology, allergy, family practice, and internal medicine; three are men; two are women. Those longest in practice had had a less structured psychosocial rotation than those who had been trained more recently. Unlike the resident sample, which is respresentative of the entire population of residents trained during a two-year period, the sample of practicing physicians has more potential to have a selection bias; i.e., those who agreed to be interviewed might over-represent proponents of psychosocial training. In recounting the influence of psychosocial training in their current medical practices, their responses most

closely resembled those of the total-effect residents. Though all were very positive about the psychosocial training now, in recalling feelings about the training during residency, responses of some were similar to those of partial and minimal-effect groups. Despite the variety of specialties, they shared common themes that recapitulated the residents' interviews.

Integration and Value of Patient-Centered Medicine

Practicing physicians shared the details of their work with an ease that reflected a patient volume and experience far exceeding their resident counterparts. Without question, they used the psychosocial training and described employing it as integrated and sometimes unconscious. Some noted that awareness of using the skills surfaced when in the company of physicians who do not use them and also on occasions when the topic of conversation is communication with patients i.e., the interviews discussed in these results.

> A lot of it I have integrated without being conscious of it, and sometimes [I] see it when I'm dealing with somebody else who hasn't had the similar types of training and watch the difference and I realize what I do.... I think they [untrained physicians] are a lot more abrupt and listen a lot less.

> If I hadn't talked to you [the interviewer], I wouldn't have realized how much I use this [psychosocial training]--how I have incorporated it into my work. Without it, I wouldn't be as good a physician.

The themes of unconscious integration of patient-centered skills in their own work and the salience of its absence in the work of others

reprises the residents' interviews. Similar parallels are apparent in exploring the skills actually used.

Using the skills. Physicians' use of patient-centered skills was consistent with the total-effect residents' reports. In their practices, they structured patient interviews using elements of the training--introducing themselves, determining how the patient likes to be addressed, using open-ended facilitators, and letting the patient set the agenda.

> I try to let them go as much as I can at their own speed unless they are really meanderers. I let them give me their feelings and then I ask basic, specific, questions.

All of the practicing physicians emphasized that much of what they do involves treating more than the biomedical symptoms of their patients. In the following example, the physician automatically incorporates open-ended questions as she talks about uncovering psychosocial issues.

> ... there are probably physicians out there who are blind to it [the number of depressed patients]. But it doesn't take much to find it. As you talk with somebody about their life and it sounds like they're kind of stressed and maybe they're not sleeping well, and having problems eating. Sometimes I've seen someone for a sinus infection and said, "How are things going? Anything new and different in your life?" and people burst into tears. Just to have someone show some concern for them and make that connection is overwhelming to them because they are so isolated in their lives.

Regardless of specialty, the practicing physicians were all intimately familiar with somatization and used the somatization model

effectively. Years after the training, they continued to include frequent patient visits, depression management, and polished explanations of the mind-body connection in their programs for somatizing patients. One physician described how she talks with patients who have irritable bowel syndrome:

> Well, we talk about the idea of the different reactivity of people's digestive systems--and that in some people, when you are embarrassed, you blush; when you are sad, you cry. And so when some people get anxious, their colon ties up in knots. [I] try to get across to people that they are having a physical manifestation of an emotional event--that we all have these sorts of things.... I find that if I present it that way, people are more amenable to, one, talking about it, and two, trying some kind of antispasmodic medications that can be so effective.

Like the residents, the physicians cited the emotion-handling skills and somatizing management techniques as the most valued communication tools. As indicated in the above example, physicians recognized that the skills facilitate compliance. Other responses implied appreciation for the efficiency gained by obtaining better, more accurate information through focusing attention on the patient's real problem. Once again, as with the total-effect residents, uncovering patients' emotions, not just responding to them, was considered to be therapeutic.

> I think when they [patients] express emotion, that's good. I always look at that as positive. If they are angry, upset or anxious or whatever you can facilitate that, you can work with that.... And they won't do that [show emotions] unless they trust

you and they know you are not going to react in a negative manner. A lot of times it is [therapeutic] I think.

I find that it [emotion-handling skills] tends to make them [patients] open up. You know if they are sitting there facing a solid wall of silence. Silence is good in interviewing sometimes, but often when you are dealing with something like this they need some sort of response. It [emotion-handling skill] allows them to go their direction without being guided by me. It gives me a better idea of what is going on.... There are times when people come in and start unloading and it's hard to respond, and this allows you to take neutral ground and still give them a response so that they continue. It allows you time to collect your own thoughts and figure out exactly what you think is happening, what we need to do about it--so it gives a little bit of a haven at the same time. You don't have to commit to anything until you get a better picture of what is going on.

[Regarding somatic symptoms] it's interesting because if you don't have the ability to find out what is behind the symptoms, you end up spinning your wheels. You end up ordering a bunch of tests, and doing this, that, and the other, and you're focused completely on the organic side, and you're not going to help those people. You really have to get down to the problem.

Specialties did not preclude the use of general patient-centered skills or the somatization model; they merely expanded the range of their

use. Cancer patients in remission worry about recurrences of tumors and sometimes develop stress-related problems. Patients are sometimes referred for allergy work-ups who turn out to have no allergies, but suffer from persistent, non-organic disease symptoms. In some situations, specialists, in addition to explaining to the patient that his or her symptoms are not caused by organic disease, have the added task of explaining the patient's symptomotology to the referring physician. The following excerpt provides a glimpse into some of the difficulties confronting specialists with psychosocial training who must interface with untrained physicians.

> One problem with being a specialist is the question of which issues do I address and which don't I address? Which ones do I refer back to the primary care physician, and which ones do I try to deal with myself? How can I go about convincing the [referring] primary care physician that this person might need a different approach to their care.... I think people who have had some experience with psychosocial medicine are generally more cognizant of these problems [somatization problems] and it's easier to call someone that I know has background like that and talk to them about what is going on with the patient than somebody who may not be in tune, and may even be opposed to the whole idea of psychosocial medicine. There are some physicians in the area that are very much oppposed and refer people off to wild diagnostic tests.

The Increasing Value of Psychosocial Training

Without question, the value of psychosocial training and using patient-centered skills increased over time for all the practicing physicians

interviewed. They indicated that they had become more patient-centered since their residency years. For at least one of the physicians, the change was made possible by becoming more confident with biomedical skills.

> In residency, I think it [using psychosocial training] fluctuated depending on the rotation I was on. [In my specialty] I am definitely more patient-centered because it is easy enough to take care of the medical problems. I'm good enough now as a physician with experience as to [know] what to do [medically].... It's easier for me to switch gears, and not have to rely on so much time dealing with the physical body....
>
> I do distinctly remember the rotation and I know it definitely impacted the way I deal with patients--probably not so much when I was in the residency, [but] I've thought of it many times since I have been in practice.

In part, appreciation grew due to discovering the prevalence of psychosocial-related problems among their own patients. Identification of the psychosocial problems is also testimony to skill use. In the first excerpt that follows, a doctor practicing for over six years, talks about his medical practice. Indirectly, he, too, indicates that inexperience, perhaps insecurity, can lead to overemphasis on biomedical issues and stifle psychosocial exploration.

> In terms of how I interact with patients, I know that when I first went into practice, the first six months or so, I think you tend to take bad results [laboratory tests] a little too literally. You tend to be a little too organically based.... I guess I've been impressed

that there is a whole lot more psychosocial issues in the complaints that we see than organic ones. And it's probably more than 50%...There are a lot of functional illnesses out there. Irritable bowel is huge; reflux esophagitis is huge; a lot of headache patients obviously. There are a lot of people who are just fatigued because of their stress....I didn't know that there was going to be this much of it. I mean I feel like I do as much as freshmen psychiatrists do.... I feel like I'm in the trenches on the front line for depression.... [the value of the psychosocial training has increased] I would say about a thousand-fold.

They told us in [residency] that we would see a lot of psychiatric problems and a lot of depression. I guess I understood that on one level, but I didn't really understand how common it is, that I would diagnose that a hundred times more often than I would diagnose someone with high blood pressure.

Although the physicians valued the training and the value appears to increase with time, as with the residents, there were varying degrees of previous exposure to psychosocial medicine and varying points in time at which they felt its positive influence. For some, the rotation was a new experience.

For me, it [psychosocial training] was an eye opening experience.

Medical school taught me nothing about patient-centered relationships. It taught me only physician-centered relationships; in fact, when I first came here, everything I did was physician-

> centered. I asked the questions, and they [the patients] answered them. And if they had a psychosocial underlie, I missed it entirely. So really, until I came here and was nudged in that direction, the general philosophy of the [program] and the residency [training], I didn't do it.

In contrast, one physician who had had some patient-centered training in medical school, was less impressed with the training initially. In recalling his feelings about the psychosocial rotation when he was a resident, he sounded much like members of the minimal-effect group:

> I hated doing tapes. I thought it was a waste of time. I thought I was pretty good at this and I kind of resented being put through what seemed like busy work at the time.... I used to hate role playing. It drove me nuts. *[I have felt differently about it] just within the last two years--since I have been out of residency.*

Nevertheless, the same physician recalled appreciating the agenda setting and time management techniques during residency and finding management of difficult patients, i.e., somatizers and borderline personalities, immediately practical. Ironically, in spite of feelings during the training that he was already competent, he volunteered that some elements were new to him:

> [What I started to do differently with patients after the training was]...really listening to their [patients'] agenda, absolutely. Mostly my medical school training was pretty doctor-oriented as far as the agenda. Even naming it as a patient's agenda I seem to remember was new to me.

Other physicians, who also had attended psychosocially-oriented medical schools, had a different perspective on the training. Similar to some of the residents in the total-effect group who had previous exposure to patient-centered medicine, they considered the psychosocial training a refinement of what they already knew.

> I think it [the psychosocial rotation] was good because it reinforced a lot of things. When you are an intern, I think you kind of get into bad habits and...the rotation is helpful in terms of addressing some of the habits and why people...forget what they've been taught.

Furthermore, reminiscent of the resident who initially had planned her career to avoid patient contact, one of the physicians had started medical school with a biomedical goal of working in a laboratory setting. The change to primary care was a result of several factors including some self-discovery: "...a bit of maturity within myself; ... looking outside myself for other things...[besides] my immediate home and family." In addition, psychosocial training, beginning in medical school and continuing through residency, also played a role in her choice.

> [I am] definitely much, much more [psychosocially-oriented] than when I started training. I really didn't consider it an issue when I started training. Honestly, when I first went into medicine, I thought my end result was going to be a [minimal patient contact specialty].... I dreaded my first medicine rotation.... [Liking working with patients]...was as much as a surprise to me as it was to family and friends around me.... even into residency I

> thought I was headed into [a minimal patient contact] direction, and then after about a year or so of residency I realized more and more that I liked practice.... I picked up more on the ideas of motivation and interaction from [psychosocial training] than I did from formal psychology, psychiatry-type teaching because it was day-to-day, one-on-one interacting with people.

Regardless of when these doctors started to appreciate the training, it is clear that being in practice has only enhanced their endorsement of it. The prevalence of psychosocial problems among their patients was one factor contributing to the training's influence. Another factor, perhaps even stronger, was the positive outcomes derived from using patient-centered skills.

The Benefits of Psychosocial Training

Reiterating the comments of the residents, physicians in practice related psychosocial training to positive outcomes for both their patients and themselves. They noted the benefits gained from better information. They also associated the use of skills with patient satisfaction and a stronger doctor-patient relationship.

> [Dealing with the psychosocial issues]...in many cases it really gives you an understanding of what is going on so it actually can make you feel like you're in a bit more control, or at least know the situation a little better.

> I think learning to let the patient set their agenda on the table for a while before you get to your agenda...strengthens the

> connection between the two of us. I think it offers a lot of trust into the relationship. I think patient satisfaction increases.
>
> One person the other day...thanked me and said that she was happy to find somebody who spent so much time answering her questions and talking to her. She thanked me and I said, "Well, you can also thank MSU where I trained."

For experienced physicians, patient satisfaction was important not only for its association with better doctor-patient relationships, patient compliance, and physician satisfaction, but also for pragmatic reasons. Satisfied patients do not doctor shop; the reality of medicine as a business was not lost on members of this group.

> Some family practitioner a long time ago said, "Listen, I don't care what you know about differential diagnosis...your patients will only come back to you if you are nice to them. Everybody wants the best quality medical care, but the ones [patients] that will come back to you are the ones you have a good relationship with."
>
> One of the things about medicine being a business is you want the patient to keep returning....I guess even if it takes more time to practice medicine in that manner [patient-centered], I think you see dividends because you see increased patient satisfaction
>
> ...people have said that they really appreciate the fact that I've spent more time with them than other physicians.

Personal rewards. Of equal importance were the personal rewards derived from positive patient feedback. Similar to many total-effect residents, the physician quoted below credits employment of psychosocial skills with feelings of accomplishment and a more positive world view. Other physicians also volunteered that the training had benefits beyond the work environment.

> People are a lot different when they don't have [psychosocial] training. I think in some ways it counters some of the cynicism that you develop so easily...I came into medical school cynical--and could have left even more cynical.... I think it is real helpful overall and to my personal life as well as my professional life.

> I use it [psychosocial skills] with family members, somewhat with friends...[I] take the basic training in the psychosocial rotation and build on it with personal experience and with other training I've gone to.

> I think you find yourself using some of those techniques in dealing with other people... like for example if you are having a tiff with somebody.... .a lot of those principles can be applied toward any aspect of your life in terms of how you deal with people.

Communicative confidence and self-awareness. It should come as no surprise that these physicians talked in terms of patient-centered skills enhancing their confidence working with patients and their sense of conversational empowerment. The confidence implied by their use of skills in

their personal lives and their receptiveness to patients' expressions of emotions is consistent with total-effect group as well.

> ...they [patients] can say anything they want to me, including... that I'm a terrible physician. If they do say something like that, then obviously we have a problem.... And I say, " Something I've just done has really upset you and if something has gone wrong, we have to try to amend this"...and [I] try to work out relationship. There are certainly a battery of techniques that you can utilize. But you don't do that in a robot fashion. You're a backboard for what they say; you basically try to facilitate.... I guess I'd probably have to say that there's probably nothing that the patient could do that would totally [throw me].

> I use it [psychosocial training] a lot more than I thought I would. It's a framework to base a lot of things on and when you are--as we were talking about NURS--when you are faltering and you're not really sure where to go next, it's a pathway you can follow to let the pieces fall down until you get enough information.

Throughout the interviews, in the contexts of describing use of skills, working with patients, and feeling confident about approaching patients on a variety of topics, physicians indicated ongoing self-awareness processes. Several remembered specific revelatory incidents during the rotation in which they recognized reactions or behaviors toward patients for the first time. They also noted that by recognizing their potential for negative reactions, they are able to employ strategies that prevent relational difficulties.

> ...It [the psychosocial rotation] made me realize...how a lot of that stuff [stresses in his personal life] was affecting the way I was dealing with my patients day-in and day-out. I was grumpy. I was preoccupied with what was going on at home instead of doing my work.
>
> [During the rotation] I can remember recognizing that I got angry at patients.
>
> [The psychosocial rotation was] one of the places that where I realized my problem was with certain types of patients...the borderline [personalities]. [That is] when I really started identifying who was cranking my case so bad.... I had one woman [borderline patient] where I made up an excuse..."Let me go check something." I'd walk outside [the examining room] for a few minutes, take a few deep breaths and go back in again.

In contrast to those quoted above, the physician who didn't fully appreciate the training until two years following residency also said that he really didn't learn much about himself on the rotation. Nevertheless, his comments provide insight into the processes of self-awareness.

> I don't think I experienced any huge personal growth during that month [of the psychosocial rotation]. Again, internship is so overwhelming and there are so many other things that you are going through, but I do think it planted seeds that grew later on, but I don't remember feeling any difference at that time.

Above, he sounds remarkably similar to the partial-effect residents in

describing his feelings of being overwhelmed at times by the psychosocial problems of his patients. In contrast to that group, he exhibited more self-awareness and more of a conscious effort toward working through those feelings. These two excerpts from his interview capture the interplay between the development of communicative confidence and the personal self-awareness work necessary to achieve it.

> ...But part of it [feeling overwhelmed] is me, too, and how I interact with my patients. So I've gotten better recently at trying to set some limits...to try to avoid burnout.... With some of my families [it] is absolutely true [that a patient-centered approach prevents burnout]. With other families, it's not true, and that could be because of my...level of inexperience. I think that as I get better about some of my personal boundaries that will become more true. For now, sometimes my personal boundaries get blurred. There are occasions that I interact with patients as though I'm their parent.

> I think it's really nice to have something concrete that you could use [emotion-handling skills]--even if you didn't feel comfortable using them at first, just to know that they were there and try them, I think helped. But when I'm feeling confident, I find that is very true. When I'm feeling vulnerable, then its not true. Especially when I am very tired, I find that I don't want to deal with it--the psychosocial stuff, or I don't want to make a conscious effort to use the skills. It does take some energy... So I think it is very helpful overall, and I think it is a

confidence builder and I think it does make you feel less helpless, and less overwhelmed.... In general it makes you feel more empowered in the situation.

Learning from physicians in practice. The current value of psychosocial training for practicing physicians recapitulated findings of the total-effect residents. Elements of the psychosocial training that were important to those residents were important to these physicians two to six years into their practices. Regardless of specialty, they found the patient-centered skills, particularly emotion-handling skills and the somatization model, extremely important to their work. They credited psychosocial training and the use of skills with improving patient satisfaction and compliance, strengthening the doctor-patient relationship, and developing their own confidence and sense of accomplishment. They all noted the importance of self-awareness and its role in building relationships. None of this differs from what was already obtained in the residents' interviews. The greatest benefit from the physicians' information is the insight gained into the processes of appreciating and using skills and self-awareness.

Regardless of how receptive they had been to the training while residents (the range among them was from resistant to very receptive), all of the physicians indicated that the value of psychosocial training had increased for them over time and all noted that the prevalence of psychosocial problems among their patients was greater than anticipated. Furthermore, some of the physicians reported that their use of skills and ability to become more patient-centered increased once they felt more confident with the biomedical side of medicine.

Similarly, the range of self-awareness work the physicians recalled

during residency also varied from none (in the physician who had been most training-resistant) to vivid memories of actively working on issues (in a physician who had been quite training-receptive). All of the physicians expressed awareness of their reactions to patients and modification of their behaviors accordingly. The physician who came to appreciate the training late and recalled no personal growth during training appeared to be the most actively engaged in exploring issues now. These interviews reaffirm that self-awareness work is never a completed task, and suggest that movement from partial- and minimal-effect levels of training influence is possible over time. In the final chapter that follows, these implications and others are explored in more detail.

CHAPTER FIVE: DISCUSSION

The focus of this chapter is an analysis and discussion of the findings presented in the results. First, a brief summary of the long-term effects of the training is presented. Next, the implications of the findings for teaching and research are examined. Finally, the limitations and benefits of qualitative methods are explored.

Summary Overview

This study was initiated to examine the long-term effects of psychosocial training on medical practice. Three levels of training influence (total, partial, and minimal effect levels) were found among residents who were interviewed two years following their training experience. Residents' communicative confidence and self-awareness increased with the level of training influence. Practicing physicians, interviewed four to eight years following psychosocial training, were most similar to total-effect residents in their integration of patient-centered skills, their appreciation of the training, and the benefits they derived from it. All of those interviewed, residents and physicians alike, had similar residency experiences--rotation requirements and outpatient clinic loads had not changed appreciably over the period studied. No demographic pattern (i.e., age, gender, medical education, personal experiences with illness) in group composition emerged as a possible predictor of training influence.

Regardless of effect level, there was consensus that the

psychosocial training infused humanism into medical education and restored a sense of humanity to those who had lost idealism during the medical socialization process. At the maximum effect level, patients were viewed holistically by their physicians, the biopsychosocial model was fully integrated into medical practice, and the practice of medicine became more interesting, more challenging, and more rewarding for the practitioners. Residents and physicians related the use of patient-centered skills to increases in their confidence communicating both professionally and personally. They also credited the skills with increased patient satisfaction, compliance, and retention. In addition, they reported that the patient-centered techniques enhanced their own satisfaction--increasing good feelings about themselves, their accomplishments, and their profession. Finally, they indicated that the training had helped them grow personally and that self-awareness and self-understanding of personal reactions to others had improved their relationships. These processes--development of confidence, self-awareness, better patient relationships, and positive personal and professional outcomes--had started during or were enhanced by the training and continued to be in progress at the time of the interviews.

At the opposite end of the spectrum of influence, minimal-effect residents commented that the training basically repeated what they had already been taught in medical school. In spite of statements of familiarity with the material, they reported using the skills far less than the other groups. Nonetheless, they used some facilitative skills and noted that emotion-handling skills, somatization management skills, and techniques for working with difficult patients were helpful and elicited positive patient responses. In the context of increased comfort working with difficult

patients, there was some evidence of expanded communicative confidence in the minimal-effect group. However, either explicitly or implicitly, they expressed discomfort in dealing with patients' emotions, and exhibited little awareness of the potential impact that such discomfort could have on their relationships with them. Residents in this group were more focused on organic disease. Psychosocial issues were not necessarily unimportant to them; rather, they were secondary concerns to be addressed when enough time was available. Instead of working with an integrated biopsychosocial model, minimal-effect residents appeared to use the biomedical and psychosocial approaches separately.

Partial-effect residents credited the psychosocial training with expanding their understanding of themselves and their patients. Furthermore, they enthusiastically noted the positive feelings and patient outcomes derived from patient-centered medicine. Although they exhibited greater and more integrative use of patient-centered skills, and more communicative confidence than the minimal-effect group, they were apt to close down emotion-seeking and pursuit of psychosocial information when feeling overwhelmed. They were more engaged in self-discovery than minimal-effect residents, but less engaged in the self-exploration than the total-effect group.

Practicing physicians were most comparable to the total-effect residents and highly endorsed the psychosocial training they had received in residency. The primary benefit of their interviews was gaining insight into the processes of enacting patient-centered medicine. For all of the physicians, the experience of being in practice--e.g., becoming more biomedically confident, dealing with a high volume of psychosocial problems

and somatic-related illnesses--appeared to foster the use of skills including those related to self-awareness and to increase the value of the training over time. For at least one physician, the change was dramatic, from a very negative reaction to the training during residency to a full appreciation of it two years out of residency.

The differences among the three groups of residents coupled with the information provided by the practicing physicians suggest mechanisms through which the training is absorbed and implemented. The next section examines those processes and their implications for education and research.

Implications for Teaching and Research

Communication is a fundamental human attribute, and people generally interact in ways that are comfortable for them. As is evidenced in this research, physicians are no exception. Each level of training influence reflected the range of topics residents comfortably explored with patients. To effect change in the way people communicate requires both that they feel comfortable with the proposed change and that they see value in it. Enacting patient-centered medicine requires that physicians broaden their communicative capabilities and use skills that will allow them to explore patients' emotional and psychological well-being as well as their physical symptoms. To the extent that physicians find these topics comfortable and valuable, they will expand their communicative repertoire with patients. The psychosocial curriculum was designed to do more more than merely present the philosophical underpinnings that promote patient-centered medicine; it was designed to provide opportunites for residents to develop comfort with skills and a sense of their value. The findings of this research corroborate

the importance of doing so and, for the most part, attest to the success of the design.

How the Training Worked

One obvious key to increasing both comfort levels and value is getting people to actually use the skills. Comfort with new techniques is attained by increasing familiarity and developing mastery. As the skills are used, then, value for the techniques is increased by discovering the inextricable presence of psychosocial factors in medical problems. Through role playing sessions, continuity rounds, and audio tape reviews of interviews, the psychosocial curriculum provided numerous opportunities for residents to practice and master skills in a supportive environment. This interplay between practice, confidence, and skill use is consistent with Bandura's (1982) work on self-efficacy in which he demonstrated the link between increasing confidence in performance of skills (self-efficacy) and subsequent skill use.

The interviews in this study indicated that communicative confidence increased with use of patient-centered skills, particularly emotion-handling and emotion-seeking skills. For some, confidence developed during the rotation itself; for others, confidence developed later as they incorporated the skills into their work. Many residents (representing all effect levels) admitted to being annoyed by the number of practice sessions during the training, but many also saw the virtue in practice later on.

Positive patient feedback resulting from patient-centered techniques appeared to reinforce, increase, and broaden the use of skills for many physicians. Positive feedback also served to enhance the value of

patient-centered medicine. However, if practice and feedback alone were enough to have residents fully integrate all of the techniques and display communicative confidence, there would not have been three levels of training influence. The critical difference among the levels of training influence centered around use of emotion-seeking and emotion-handling skills and evidence of self-awareness. This corroborates Smith's contention (1986) that once interviewing skills are learned, their lack of use generally reflects unrecognized feelings on the part of the residents.

Talking about emotions, whether ones' own or those of others, can be uncomfortable. The second key to increasing the communicative comfort range is helping residents deal with emotions, starting with their own. The psychosocial faculty promoted self-exploration by integrating the self-awareness component into all the practice sessions and providing a respectful, confidential environment in which to do so. One of the messages conveyed through self-awareness work is that the residents' own feelings and reactions are important. During training, in a process paralleling what they are taught to do with patients, the residents become the recipients of emotion-handling and emotion-seeking skills; their feelings are named, understood, respected, and supported. As the value of recognizing and managing their own emotions and reactions was more fully understood on a personal basis, most residents seemed to become more willing to use skills that both elicited and responded to emotions of patients. This was not true for all; some remained uncomfortable and discounted the importance of pursuing emotions. Some also appeared reluctant to assess their own reactions to patients. Even the most reluctant, however, found utility in techniques to identify and work with difficult patients.

Implications for Teaching

Overall, the MSU psychosocial curriculum was very effective, particularly when viewed with the expectation that full impact may not be reached until long after the training is completed. This research suggests that faculty should essentially continue to do what they have been doing: focusing both on skills and attitudes (e.g., confidence in skill use, receptivity to training) to achieve maximum learning potential. Of the two factors, development of positive attitudes appears to be the most critical to actual use of patient-centered skills.

There were numerous individual differences affecting the initial receptivity to psychosocial training. Even among the total-effect residents, there was variability in when the rotation was first appreciated--its meaning and value evolving in a very individual manner. As is always the case in education, lessons are provided by the students as well as by the teachers. There are several lessons to be learned from the differences in residents' responses to the training that may help faculty to foster positive attitudes toward psychosocial training.

First, residents may benefit from learning about both the quantitative and qualitative research findings associated with the use of patient-centered techniques. A scientific overview of the positive effects of patient-centered medicine presented in the initial phases of the rotation may be particularly beneficial for individuals with a cognitive learning style or a pronounced biomedical orientation. In addition, the validity of the training might be further enhanced by openly acknowledging varying degrees of use and receptivity to it. For example, third-year residents known to be either frequent or infrequent users of patient-centered skills could discuss the

training retrospectively with groups of new trainees, essentially debating its effectiveness, efficiency, and value.

Second, differences in receptivity underscore the importance of the learner-centered/teacher-centered approach used in the training. This approach in education is the counterpart to the patient-centered/physician-centered approach taught to the residents. It focuses on partnership-building by encouraging learners to define and work on goals that are important to them during the rotation. This is crucial for all residents, but may be particularly important for those who have had prior exposure to psychosocial training and those who are potentially "minimal-effect" types. For these residents, encouraging self-determined objectives should provide focus and give immediate, personal value to the training that might otherwise be absent. Since there is currently no reliable way of identifying *a priori* how residents will be influenced by the training, learner-centered objectives should be emphasized and developed consistently throughout the rotation.

Just as physician-centered goals are integral to patient care, teacher-centered objectives serve the same function in the educational environment. It is important to note once again that many of the elements of the training were highly lauded, but only in retrospect. If left solely to their own devices, many residents during the rotation would have opted for far fewer patient interviewing rounds, role play, audio tape recordings and less self-awareness work. These teacher-centered elements are hard work and the backbone of the training. Practice and mastery of skills is the first step to communicative confidence. Both resident and physician interviews suggest that criticisms concerning the amount of time spent in different

forms of practice should be respected and modified when appropriate, but medical educators should be cautious about actually reducing the amount of practice interviews required.

Third, differences in evidence of self-awareness among residents indicate possible directions for self-awareness work. Excerpts from the interviews showed the range of receptivity to the self-awareness component varied just as with every other element of the training. There were residents who, recognizing the potential to improve their patient relationships, were open to discussing personal issues that evoked reactions to patients. There were also residents who clearly avoided topics with patients, were uncomfortable with emotions, and/or indicated resistance to working on personal issues and reactions to patients.

The impact of this distinction can be illuminated by considering some of the typical patterns seen in physician-patient relationships. Marshall and Smith (1995) described common reactions to difficult patients as externally-focused and enumerated several patient characteristics (e.g., somatizers, challengers, self destructives) that generally elicit understandable negative responses such as frustration or anger. In contrast, they described internally-focused reactions as unique to the physician, personal and intense, and manifesting themselves in behaviors that may be surprising to others.

Understanding internally-focused reactions was embraced by total-effect residents, but resisted by the minimal-effect group. The universality of encountering difficult patients and the appreciation of learning to manage them is a common denominator among all groups. As such, it is safe ground for discussion. These interviews suggest that the

least-threatening starting point for self-awareness work is with externally-focused reactions. This is not to say that internally-focused reactions are to be avoided. Rather, this analysis suggests that when resistance to internally-focused self-awareness issues is evident, a retreat to externally-focused reactions may be warranted and actually enhance the learning experience by increasing receptivity.

Internally-focused reactions clearly need to be addressed and are at the heart of relational progress, but the readiness of the individual is critical to success. Moreover, success in working with internally-focused issues may require more experience on the part of the faculty. Consequently, learning to help residents work with externally-focused reactions may be an appropriate starting point for new psychosocial faculty as well.

A final lesson provided from these residents and physicians relates to their comments about timing and length of the psychosocial training during residency. There is much to recommend that training be conducted early in the first year of residency while residents' exposure to patients is relatively new and before the stress and fatigue of the first year has affected them. For the majority of residents, four weeks in the first year appeared to work well.

On the other hand, there are patterns of responses that suggest a variant in the schedule may be more productive for a significant minority. Several of those interviewed indicated that they began using patient-centered skills after they felt more secure in handling the biomedical problems of their patients. Others, particularly in the partial-effect group, expressed feelings of being overwhelmed by their patients' psychosocial

problems and recommended a shorter rotation, two weeks. Ostensibly because there was not enough material to warrant a four-week rotation, members of the biomedically-oriented minimal-effect group also recommended a shorter rotation. Notably, one minimal-effect resident who supported a shorter rotation also said that he wouldn't mind having two weeks in his third year of residency.

The probability that residents will feel more biomedically competent in their third year, coupled with the evidence that enacting patient-centered medicine is a process of developing confidence in using skills and self-awareness, points toward exploring alternatives to the four-week block during year one. Although pragmatic considerations may preclude implementation, for some residents there may be potential benefit in offering the training in two mandatory two-week blocks during years one and three, or offering a supplemental, optional two week rotation in year three. Exploration of optimal teaching schedules merits study.

Implications for Research

From a research perspective, there are three major areas of interest raised by this study. The first involves an examination of these findings in the context of other assessments of MSU's psychosocial rotation. The second involves understanding the process of the training's influence and the third involves the relevance of the training to other areas of research.

Expansion of Psychosocial Research Evaluation

This research was part of larger study evaluating the efficacy of the MSU psychosocial curriculum. Quantitative measures of the training's impact on residents' knowledge, attitudes, and interviewing skills as well as

assessments of the impact of the training on their patients were collected. In addition, residents completed formative evaluations immediately following their training. In a similar fashion, psychosocial faculty recorded their personal reactions to each teaching experience as well as their subjective opinions of residents' receptivity to the training. These data provide numerous opportunites to expand the program of research further. For example, quantitative data and teacher reactions could be compared to the qualitative findings. Residents' responses on the formative evaluation could be compared to their interview responses two years later. Although there are obvious limitations due to sample size, such comparisons may yield interesting insights as well as directions for future research.

The Process of Becoming Patient-centered

In this study, no resident or physician ever said, "The training used to be important to me and now it's not." Even those least influenced by the training commented that they had been reminded of the humanistic side of medicine. The direction of the impact of psychosocial training on medical practice, for both residents and physicians, was unequivocally toward a more patient-centered approach. The indication by some of the practicing physicians that they might have been at minimal or partial-effect levels at the end of their residencies is intriguing, and raises the question of whether the minimal and partial-effect residents will continue to progress in their use of skills and the value placed on them.

Certainly, the prediction based on this study would be that they will. Partial-effect residents had a very cognitive approach to the training. They talked about thinking about psychosocial aspects of patient care and about its becoming "part of your system." This type of comment is

consistent with the expectations of Perry's (1970; 1981) theory of ethical and intellectual development in adult students. Brown and Weston (1995) discussed Perry's ideas in relation to patient-centered training noting that through residency, preference for simpler solutions evolves into more complex thinking, and finally into enactment--all of which takes time. Partial-effect residents seemed to be in the process of that struggle. Minimal-effect residents seemed to be focused more on biomedical issues, using patient-centered skills at a very basic level. To fully understand the impact of psychosocial training, it is essential that members of these groups be interviewed periodically to monitor changes in their assessments of the training, of their work with patients, and of themselves.

An alternative perspective on the process of adopting a patient-centered approach is Prochaska and DiClemente's (1983) stages of change model. Originally developed to describe the change process in psychotherapy, the model has also been used to describe self-change stages associated with health behaviors (McConnaughy, Prochaska, & Velcier, 1983). In the model, four stages are identified: precontemplation, contemplation, action, and maintenance. Precontemplation refers to a stage in which individuals are unaware of any behavior that requires change and consequently, have little desire to do so. The contemplation stage occurs as individuals begin to recognize that a problem exists and that change would be beneficial; in this stage no commitment to change has been made, but information is desired. In the action stage, the individual is actively started to initiate new behaviors and is struggling to change. Finally, in the maintenance stage the individual has made the change and may seek ways of reinforcing it.

Although this model has most recently been used in health campaigns, it provides a conceptual framework for the processes of adopting a patient-centered approach. For example, when residents first begin psychosocial training, they may be at any one of the stages mentioned. The minimal-effect residents who were interviewed appeared to have been in a precontemplative stage during the rotation and were still at a precontemplation stage two years following the training. Partial-effect residents and the "aha" subgroup of the total-effect residents began their training in a precontemplative mode, having never thought about psychosocial medicine prior to the training. They appear to have moved to either the action or maintenance stages, respectively, by the time of the interviews. The total-effect residents who were predisposed to patient-centered medicine would most likely have come to the training in contemplative or action stages.

Interestingly, McConnaughy and her colleagues (1983) noted that the stages are not always discrete nor necessarily unidirectional or successive. This aspect of the process seems applicable to this study as well. Partial-effect residents, for example, demonstrated elements of two stages. Consistent with the contemplative stage, they had a cognitive orientation to the training (i.e, liking to think and read about psychosocial medicine); consistent with the action stage, they appeared to be struggling with implementing all of the patient-centered skills.

This conceptualization captures the varying receptivity individuals may have to any suggested behavior change. It may be useful for educators in helping them to set realistic goals for themselves and their trainees by expanding their understanding of what defines successful

teaching. Helping a strongly precontemplative individual move to a contemplative stage within a four-week rotation is a challenging goal. The application of the stages of change model to psychosocial teaching further underscores the suggestions for educators discussed previously. It is essential that the curriculum be flexible and contain components that relate to all the potential stages represented among the trainees. Moreover, the stages of change model has implications for educational research as well. A program of research could be developed to test the effectiveness of various teaching strategies on facilitating change.

Relevance to Other Research Domains

Emotional intelligence. Examining communication skills in a specific context runs the risk of applying and thinking about those skills too narrowly. The skills discussed in this study have been labeled patient-centered skills, but at their center lies seeking and handling emotions, both others' and one's own. These are some of the critical skills of emotional intelligence which Goleman (1995) argued is equally if not more important than IQ. He relates low emotional intelligence to relational problems, depression, and poor physicial health. In his book, Goleman (1995) outlined ways of increasing emotional literacy and highlighted the curriculum of the Self-Science class at a private school in San Francisco. He considers the class a model of teaching emotional intelligence; the topics include:

> ...self-awareness, in the sense of recognizing feelings and building a vocabulary for them, and seeing links between thoughts, feelings, and reactions.... Self-awareness also takes the form of knowing your strengths and weaknesses....Another emphasis is managing emotions: realizing what is behind a feeling

> (for example, hurt that triggers anger), and learning ways to handle anxieties, anger, and sadness.... empathy, understanding others' feelings and taking their perspective, and respecting differences in how people think about things.... Relationships... including learning how to be a good listener and question-asker, distinguishing between what someone says or does and your own reactions and judgments, being assertive rather than angry or passive, and learning the arts of cooperation, conflict resolution, and negotiating compromise. (p. 268)

If Self-Science is a model for teaching emotional intelligence then so is the psychosocial rotation whose curriculum encompasses all the components that Goleman described. The skills taught to the residents are generalizable, "people-centered" communication skills that have applications and implications beyond the confines of medicine. According to Goleman, for a better society, the skills taught in Self-Science (and the psychosocial rotation) should be taught in elementary schools and should be understood by parents so that pre-school children can be mentored in understanding and expressing their feelings.

The research potential associated with these skills is as varied as the contexts in which the skills can be taught. Currently, the skills are relevant to several research domains of interest to communication scholars including social support, empathy, and burnout. Some examples of areas for exploration are briefly outlined below.

Social support. Social support scholars have long searched for insights into the interactional aspects of support. One focal area of research is on support-seeking messages. Of specific interest are indirect requests

for support because recipients' perceptions of what they receive is greater when they make indirect requests than when they must ask for help directly (see Albrecht, Burleson, and Goldsmith, 1994 for a discussion).

During psychosocial training, residents are taught specifically how to make supportive comments to patients; in addition, they are taught to pick up patients' distress cues (indirect requests for help) and to respond. Total-effect residents' interviews demonstrated that information and emotions were elicited from patients using facilitative, emotion-seeking and emotion-handling skills. In the excerpt involving the patient whose mother had an eating disorder, the patient was prompted to reveal concerns and the physician responded by providing support (both emotional and instrumental) without having been asked directly for help. The patient's perception of social support, long touted for its protective health benefits (see Cohen & Wills, 1985), may have been bolstered as a direct result of the physician's use of these skills. The specific relationship between use of these "people-centered" skills and social support dimensions needs to be explored further both within and outside the health care context.

Connections to burnout and empathy. In addition to being the enactment of social support, patient-centered skills also inform our understanding of other communication concepts. The skills are remarkably similar to Miller and Knapp's (1986) description of reflexive talk (which includes open ended questions, refections of emotions, use of silence) that they found was the most appropriate communicative strategy to use with dying patients. Further, the use of these skills may be the actual behaviors that underlie individuals' perceptions of communicative responsiveness.

Communicative responsiveness (Stiff, 1984) is measured by assessing "a person's perception of his or her ability to communicate with others who are experiencing distress" (Miller, Stiff, & Ellis, 1988; p. 257). It is a person's sense of effectively putting empathic concern into action and is associated with reduced burnout (Miller, Stiff, & Ellis, 1988; Miller, Birkholt, Scott, & Stage, 1995). This research reinforces the findings of Miller and her colleagues and helps to increase understanding of these relationships.

Total-effect residents and practicing physicians, who were more communicatively confident and adept in their use of patient-centered skills, talked about feeling a greater sense of personal accomplishment, the antithesis of one of the burnout dimensions (Maslach, 1982), through use of patient-centered skills. Unlike some of their colleagues who were overwhelmed by patients' problems and showed symptoms of the two remaining dimensions of burnout (emotional exhaustion and depersonalization of care recipients), total-effect residents and physicians had redefined what it means to help a patient. They did not attempt the impossible task of solving all of their patients' psychosocial problems. Instead, they recognized the benefits of supportive communication and noted that over time, by listening and talking to patients "you can see changes in some of these individuals ....they are not as angry....their idea about how to cope with life changes." These doctors were responsive to patients' emotional needs and problems, felt confident in their communicative abilities, and also felt good about their work.

There is an obvious relationship between communicative responsiveness and communicative confidence that needs to be explored, as

does the strongly suggested relationship between psychosocial training, communicative responsiveness and burnout. Miller, Stiff, and Ellis (1988) commented on Maslach's (1982) lament that "interpersonal skills are often considered secondary to other professional skills of caregivers" (p. 263). As an antidote to caregiver burnout, they advocated Maslach's ideas for interpersonal training that would include how to develop and sustain relationships with care recipients, how to adapt to a variety of situations and people, and how to discuss difficult topics. This research suggests that the psychosocial rotation is the realization of that interpersonal training; its impact should be explored in a variety of contexts.

The Limitations and Benefits of Qualitative Methods

One obvious limitation of qualitative research is that it is labor intensive. In this study contacting and interviewing subjects, transcribing tape recordings, and coding the interviews alone required hundreds of hours and more than two years--for a sample of twenty-seven. In qualitative research, what is lost in large sample numbers, is hopefully gained in the richness and completeness of the data. Nevertheless, small samples still raise questions regarding representativeness. In addition, response bias, particularly the social desirability of responses, may be of concern to some readers.

Representativeness of the Sample

Seventy percent of the residents in the two classes identified for study were interviewed for this research. Those two classes represent the entire population of interest; consequently, a sample of 70% of the population should be adequate. Grounded theory methodology focuses on theorectical sampling procedures; i.e., the representativeness of a

phenomenon in the data. In the sample interviewed for this study, phenomena such as levels of training influence and communicative confidence were repeated in the data, with no new concepts emerging. This is an indication of saturation (Strauss & Corbin, 1990). Had additional residents been interviewed, the expectation would be that they would fall into one of the categories already identified. The proportions of residents in the categories might change as a result, perhaps creating a more even distribution, but fundamental findings about the impact of the training would not be influenced.

Representativeness is somewhat more problematic with the practicing physicians. However, the purpose of those interviews was focused on gaining insight into long-term influences of psychosocial training. A selection bias among the practicing physicians, if it existed, would mean that there may be some physicians in practice for whom the value of the training did not increase. Such a finding does not negate the fact that for many, even some for whom the value was minimal initially, the value did.

Response Bias

There is always potential for response bias in subjects regardless of methods and precautions employed. It is possible that there was an element of politeness that permeated the responses of some of the residents. They were all aware that research was being conducted on the effects of the psychosocial teaching and had participated in the quantitative evaluation immediately before and after their training. They were also aware that the two people who conducted the interviews worked on the research project associated with the teaching. However, the interviews were conducted approximately two years after the training when residents' plans

for fellowships or private practice were complete, and concerns about pleasing faculty should have been minimal.

More important to the prevention of bias in the data was the method of conducting the interviews themselves. The second generation of interviews involved a longer protocol and the residents were interviewed in a manner that paralleled their training with patients. The interviewer used facilitation skills, emotion-seeking and emotion-handling skills in tracking the conversational threads presented by the residents. These skills, used to elict accurate patients' stories (see Smith & Hoppe, 1991), were used to elicit the residents' stories. The interviews were not conducted perfectly; there is evidence in the transcripts of the interviewer's interrupting and shifting topics. Nevertheless, the detail and enthusiasm for patient-centered care from the total-effect residents and the feelings that the training wasted their time from minimal-effect residents flowed easily in response to questions. The excerpts of the interviews presented in this research attest to the overall candor of the responses.

The Benefits of Qualitative Research

Quantitative results assessing the effects of the psychosocial training indicate that trained residents interview patients better, their patients are more satisfied and have fewer somatic symptoms, and that they have greater self-efficacy in psychosocial skills than untrained residents (Smith et al., 1996). This qualitative research both corroborates and expands those findings. The interviews provided a glimpse of processes: how the training works, how confidence develops, the interplay of self-awareness with use of skills, and residents' sense of satisfaction with their work. In addition to these processes, qualitative methods revealed the

impact of the training on those whose psychosocial interest, and perhaps skills, were highly developed before the training. These are the subjects who would show no movement on quantitative measures, but who gained as much, if not more, than other residents. It is important for educators to know that the training is meaningful to this group and to gain understanding of those who appear resistant or ambivalent about the training. Such information is unlikely to be discovered with quantitative measures alone.

A second major benefit of qualitative methods is the education it provides for researchers both professionally and personally. Part of the initial preparation for this study was spending time as a participant-observer on a psychosocial rotation. It was an invaluable experience and greatly enhanced understanding of how faculty enact the teaching objectives and of the interplay of responses between teacher and learner. One resident on the rotation was actively and openly engaged in self-awareness work; another was participatory, but quite reserved. Observing the impact of individual differences at work and observing the faculty apply the interviewing skills while teaching the residents provided a clearer understanding of residents' experiences on the rotation, and ultimately of the meaning of patient-centered medicine.

The process of actually collecting the data for this study was equally valuable. It was a unique mulitdimensional learning experience that included learning about doctors working with patients, learning about conducting interviews, and learning about one's self--each topic shift or interruption appearing on an interview transcript was an opportunity for the researcher's self-discovery. Conducting and analyzing these interviews was challenging and all-consuming. It was also often an uplifting and sometimes

a moving experience--something seldom said of quantitative research.

APPENDIX

APPENDIX

Interview Protocols

Second Interview Protocol:

Communication with Patients/ General Residency Experience

I am interested in how physicians work with patients--not in what physicians **think** they should do, but in what they actually do--I realize the clinical situation sometimes does not allow for the ideal. I am particularly interested in how physicians work with patients' personal problems. Tell me about your experiences.

Has there been anything in your experience to help you with that aspect of patient care?

1. Tell me how you generally structure a medical interview with a new patient. For example, suppose I am your next scheduled appointment--a new patient who has come to you for a physical because of problems with indigestion. (What do you typically do--not what you should do--first when you walk in the room? What do you generally say first?)

    Are there certain interview "rules" you follow? What are they?

    Where did those rules come from?

2. Suppose during the course of this appointment, I tell you that I have been having symptoms of constipation, diarrhea, indigestion, and fatigue for about five years, have seen several doctors in the past, but no one has been able to help. My medical history reveals no unusual childhood illnesses; no surgeries or hospitalizations; no tobacco use; occasional alcohol use. However, I do take Valium 10mg a few times a day and use antacids. You do a physical exam find everything normal; CBC, SMAC, urinalyasis are all normal. Upon obtaining my records, you find that I was evaluated for the exact same thing four months ago at which time I had an upper GI, BE, sigmoidoscopy, stools for blood, stools for ova and pararsites etc, all of which were normal. I had similar tests (normal) two years ago. You conclude that I have been adequately tested and have no organic disease--

    What do you tell me on the return visit?

    What do you do about people like me?

    How would you be thinking and/or feeling about these types of patients?

How many patients like me do you see? (Maybe not difficult to you personally, but generally considered difficult?)

3. Do you avoid talking about some things with patients in a first visit?

   What kinds of things?

   Do you avoid talking about some things in general?

   What kinds of things?

   What, above all else, do you try to accomplish on the first visit? What about a return (follow-up) visit?

4. Are there things patients say that make you uncomfortable?

   What kinds of things?

   How do you handle that?

   Anything that you do that makes patients uncomfortable?

5. Is there anything that patients do that you find particularly annoying?

   Difficult to deal with?
   (patients asking a lot of questions, patients who are angry)

   What do you do in those situations? (How do you handle those situations?)

   What do you think or feel in those situations?

6. How did you learn to deal with those situations?

7. What was the most useful part of your residency training in regard to learning to communicate with patients? How so?

   What did you learn? Where?

   (outpatient clinic experience, B-service, particular rotations, attending physicians, residents)

8. What should there have been more of in your residency program? Less of?

   (What was most/least useful?)

<u>Psychosocial Rotation</u>

9. You had psychosocial training as part of your residency program, tell me about the training?

   What you recall about your experiences on the psychosocial rotation? Positive? Negative?

(what do you remember most about the training? -- your personal perception of the training)

Any vivid incidents with patients or involving other residents on the rotation that you recall? That were meaningful? How?

Any vivid memories involving the faculty??

10. What elements of the training were most important to you at the time?

(examples: basic interviewing skills, somatization skills, emotion-handling skills)

What about now? What do you wish there had been in the training for you.

11. How has the training affected your later work? After the training was there anything in particular that you noticed that you did differently with patients?

Has that continued?

What difference did/does it make?

How would you say that the training has contributed to your relationships with your patients?

Did the ps training change your view of patients in any way?

Are you better with some types of patients than others? (which types? in what way?)

12. Tell me how (what) you actually use from the training? (specific interviewing skills, emotion handling skills, informing and motivating format) (ask for examples of use--patient types, contexts: inpatient, outpatient)

What happens when you use _____? What happens in a similar situation when you don't use it? How does using _____ change/influence the outcome for the patient?? example

When did you start to use _____? (first year, just recently)

Do you have a specific memory of first using _____/ a specific patient?

Are there kinds of circumstances that trigger its use? example

Now that you are an attending (3rd year resident/in practice), how often do you use the techniques?

There are several components of the training that you didn't mention using; e.g. _____ Why not?

What hinders you from using elements of the training? What is hindered? Is the training efficient? When?

Have you become more or less psychosocially oriented since your first year of residency? (difference between first, second, third year, medical practice?) What in the residency program/medical practice reinforces or does not reinforce the training?

13. What in the training didn't work for you then?/What was least useful or seemed irrelevant/annoying?

(Why? Would it work now ?)

Was there area of the training that you thought was particularly difficult? What about it was difficult? Is there a specific incident that comes to mind?

How difficult would you say the rotation was in general? More or less difficult than you expected??

14. Did you learn anything about yourself while you were on the rotation? (How you react to patients, for example? specific issues?)

Do you use any of the self-awareness training you received? How?

Generally how has self-awareness influenced dealings with patients?

You mentioned earlier that you prefer to avoid (find difficult, annoying) _____ and _____. Did the training give you any tools to deal with these types of situations.

15. Has the rotation influenced you on a personal basis/ do you use it outside medical practice? With whom? When? What do you use?

16. Overall, how would you say the <u>psychosocial rotation</u> has influenced you?

What effect do you think it has on your medical practice?

Has it influenced your future choices--primary care (positive or negative), specialty?

Initial Protocol:

Follow-Up Interview Questions for Residents Completing the Psychosocial Medicine Rotation

What is your overall perception of the psychosocial rotation?

How has it affected your work?

What do you remember most about the training? (Do you have any specific memories?)

The basic training components included interview techniques, seminars and tape sessions, discusssion of personality types, self-awareness, C-L, what elements were most important to you?

Was there anything that didn't work for you?
Anything that you needed and didn't get? (Or would have liked to have spent more time on?)

Tell me what you use from the training (how do you use it--under what circumstances? Do you use it in your personal life?)

What constraints have hindered you from using the training?

What in the residency has reinforced or not reinforced the psychosocial rotation experience?

Have you changed your mind about the training in the past few years? (Prior to training you come in with certain ideas, have there been changes over the last two years? Tell me about them?)

How have you changed as a person humanistically and scientifically as a result of the training?

How has your experience with the MSU residency influenced your later choices? What about the training has influenced you?

Overall, what has been the most helpful aspect of the experience.

What has been the least helpful?

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