Teaching Self-awareness Enhances Learning about Patient-centered Interviewing

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ABSTRACT

Purpose. To evaluate the effect of intensive attitudinal training on residents' learning the patient-centered interviewing skills required to establish a healthy provider–patient relationship and to communicate effectively.

Method. While teaching 53 residents patient-centered interviewing skills, the authors also trained them to recognize previously unrecognized, negative attitudes that interfered with learning the skills. The authors, using an iterative, consensus-building process based on the residents' performances and personality data, identified a spectrum of responses to the educational intervention. Barriers to and facilitators of mastery of skills were analyzed and this information was used to help residents overcome skill deficits.

Results. To varying degrees, 44 residents became aware of previously unrecognized attitudes to the extent that they improved their patient-centered interviewing skills. Six residents failed to develop awareness of negative attitudes and showed little learning and clinical use of the interviewing skills being taught. Three residents who rapidly developed superb interviewing skills showed no negative attitude towards using them.

Conclusions. Pending a confirmatory hypothesis-testing study, the authors believe that, as residents learn how to conduct patient-centered interviews, training in awareness of interfering attitudes should accompany training in skills.

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Patient-centered interviewing skills have been linked with a number of positive health outcomes and, conversely, the absence of such skills has been linked with negative outcomes such as patient dissatisfaction and malpractice suits.[1–9] But physicians' negative attitudes can interfere with their learning patient-centered interviewing skills.[10–15] These attitudes are the often incompletely recognized feelings, moods, ideas, and opinions that determine whether learners are willing to use a skill,[14] particularly a complex new skill that may be counterintuitive. Only when learners are *willing* as well as *able* to use newly learned skills can educators be satisfied with their interviewing instruction. This requires that educators focus training not only on the development of skills, but also on the development of *attitudes*,[14] a subject they rarely teach systematically.[12,15,16] Developing learners' awareness of interfering emotions and beliefs is a powerful way to change their frequently negative attitudes toward unfamiliar skills such as interviewing,[12,14,17] which includes the provider–patient relationship as well as communication.[17]

Learners are being asked to acquire skills that often conflict with old, well-entrenched attitudes.[10] For example, they learn to yield control as part of being patient-centered, but this often opposes their lifelong experiences, where being in control has been comfortable and effective. Other common attitudes and beliefs that conflict with instruction in interviewing skills include[10,17]: the need to be pleasing (versus addressing painful, unpleasant issues); emotions are harmful and should be avoided (versus addressing emotions); interrupting is rude (versus strategic courteous interruption); doctors should keep their distance from patients (versus actively relating in a professional way); there is nothing to do for some patients (versus being present and supportive even with the most incurable patients); patients can't protect themselves (versus recognizing patients' abilities to set limits); and patients are weak (versus recognizing their strength to address difficult problems and emotions). Alarmingly, previous research (although rare) shows that almost all doctors[11,17] and students[10,17] harbor these unrecognized, potentially harmful attitudes. With so many attitudes in potential opposition to newly learned patient-centered interviewing skills, it should surprise nobody that we propose that addressing stu-

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dents' attitudes might improve their skills.[10]

We propose that attitude training is a long-missing but essential concomitant of training in interviewing skills. We report here the results of an extensive qualitative study where we taught self-awareness of negative attitudes to residents. The skill-training method we used in this study[17] was supported by a recent randomized controlled trial[18] and comprised five patient-centered steps: (1) putting the patient at ease, (2) setting an agenda, (3) non-focused interviewing, (4) focused interviewing, and (5) transitioning to a doctor-centered interview. We emphasized using open-ended, emotion-seeking, and emotion-handling skills to develop the patient's biopsychosocial story. This process allows patients to express their ideas, needs, and concerns without interference from interviewers—the definition of patient-centeredness—and allows interviewers to establish healthy relationships and effectively communicate with patients.[17]

Our research question was: How does teaching residents to recognize (and change) previously unrecognized negative attitudes affect their abilities to learn patient-centered interviewing skills? We expected that all participants would have unrecognized interfering attitudes, and that about half would develop enough awareness of those attitudes that they would improve their interviewing skills.[10,11] To ensure that our observations were not due simply to an initial lack of skills, we waited until the residents had first demonstrated the ability to use basic interviewing skills in role play, which all could do after the second or third teaching session.

Method

All the authors have long-standing interests in and experience with qualitative research and self-awareness training.

Teaching. This article presents one part of a five-year study of the impact of intensive patient-centered interviewing training on residents.[18,19] From 1990 to 1995, all PGY1 medicine and family practice residents at Michigan State University College of Human Medicine took a required one-month (full-time) rotation that focused on basic patient-centered interviewing, patient education, managing somatizing patients, and practical management of common psychological problems in primary care.[18] We integrated self-awareness training throughout.[13,20,21]

Using the same facilitating skills that we taught residents to use with patients, we facilitated the residents' self-awareness of previously unrecognized emotions and behaviors. We directly observed the residents as they role-played physician–patient interactions and as they interviewed real patients. We also indirectly evaluated them via audiotaped interactions with clinic patients. Afterwards, as part of critiquing those interactions, we helped the residents become aware of attitudes that interfered with their conducting a patient-centered interview; e.g., a resident's personal fear of death may have led her to avoid the patient's many references to death. At each of 20 to 25 critiques per resident during the one-month rotation, we systematically addressed self-awareness issues before discussing skills. We initiated teaching by inquiring about the resident's personal response to the patient or the patient's circumstances (e.g., "Before we talk about the interview, what were your own emotional reactions?"). For the first five to ten minutes of the critique, we open-endedly developed the resident's story, careful not to insert our own ideas into the conversation, and used relationship-building skills as the situation required (e.g., "That was a tough spot for you"). If the resident did not mention untoward, possibly harmful behaviors that we had observed during the interaction, we introduced the behavior and facilitated the resident's response (e.g., "You seemed to ignore her comments about not liking her doctor"). The sole criterion for rating an interfering attitude or behavior as previously unrecognized was confirmation by the residents, when asked directly, that it was, indeed, previously unrecognized. Management of these responses over time involved maintaining self-awareness as an objective, developing awareness of previously unrecognized emotions and behaviors, deciding whether the newly recognized responses were harmful or helpful, addressing and managing harmful responses, and reinforcing helpful responses.

Sampling. We derived our data from 53 residents, who were trained in groups of three to four. There were 27 men and 26 women, of whom 27 were international graduates. The large number of participants provided adequate representation of atypical cases.[22]

Data collection and synthesis. Relying on participant observation, we used field notes from resident teaching and critiques to capture the highly personal information required.[23] Experience and research indicate that teachers serving as investigators produce significant quantities of information not previously known about learners.[10,11] We guarded against favoring our preconceived notions by systematically collecting and analyzing the data and by having an outside investigator unconnected to the project (RMF) confirm our results. The summarized data reflect teachers' observations of many patient interactions for each resident as well as from observing multiple interactions of residents with teachers and others on the rotation. Teachers frequently discussed with each other their observations of individual residents and gradually developed a consensus about each resident, which was formalized at the end of the rotation. We used a similar iterative process in developing the categories and themes described below.

We were guided by a grounded-theory approach.[24] Each teacher elicited

and recorded data daily, including specific statements and questions, and made systematic field notes weekly. We initially categorized individual residents in many different ways and then reassessed them in an ongoing way, after observing additional interactions, to further refine our observations. We also performed teaching interventions with residents based on these observations, noted the results, and further refined our data. Through this inductive process, we developed summary hypotheses about how self-awareness training affected each resident's learning and use of basic interviewing skills.[24,25] We confirmed our observations in discussions with the other two teaching team members. Finally, we asked a colleague with extensive experience in qualitative research, who was unconnected with this project (RMF), to review the categories and findings to confirm our thinking.

After each group completed training, we identified sometimes-new categories of importance, given our research question. We also explored many combinations of data, especially as the number of subjects increased, and we identified new questions (e.g., what happens to those in whom we were surprised to find no interfering, negative attitudes?). We applied conceptual labels to the data, grouped data in categories, explored relationships among categories, and then rechecked our categorizations against the primary data to ensure that the interpretations were fully data-based.[24–26]

As part of this iterative process, several categories evolved concerning residents' personality characteristics (based on specific criteria[17,27]); their abilities to establish relationships with teachers, other residents, and patients; their abilities to elicit and respond to patients' emotions; their abilities to express emotions; their unrecognized personal responses (using our previous definitions for eliciting them[13,20,21]); their life stressors and other personal data; their reactions to training; and their responses to training modalities that are necessary to address self-awareness, such as role play and discussion.

The teachers rated the residents' success in conducting the basic interview and probing the depths of the patient's story, their willingness to engage the patient, and their confidence with the patient-centered process. We corroborated those ratings by systematic evaluations of interviews with real and simulated patients.[18] These ratings were summarized for each resident in a large matrix to permit a cross-case analysis.[28] Requiring a higher degree of abstraction, these categories were then integrated to form our results by searching for the central themes in the data. We frequently returned to the data to validate the themes and to see that spurious and rival explanations were excluded.[28]

Results

From our analytic process, we identified several themes that allowed us to link the residents' performances during the teaching block with their personality and interpersonal characteristics, which were observed in other contexts. We classified 26 of the 53 residents as having predominantly controlling personality features, including three where this feature interfered seriously with their learning and using interviewing skills.[17,27] Two residents were classified as passive-aggressive to the extent that this also interfered seriously. One additional resident was sufficiently withdrawn and depressed to interfere seriously with learning and using the skills. These six residents comprised the training failures noted below. We made the following additional personality style designations, all within the normal range and not preventing learning: six passive, three flamboyant/demonstrative, one passive-aggressive, and 14 mixed.

Eleven residents showed no emotion; eight were controlling, including the three serious instances above. We classified three residents as establishing poor relationships with teachers or other residents, two of whom were the serious passive-aggressive instances above, while the other was one of the serious controlling personalities; none of those three residents readily expressed emotions.

From the data, we identified the following five categories of responses to self-awareness training and related them to success in learning interviewing skills. (1) Six residents were *self-awareness training failures*; we could not help these residents become sufficiently aware of or take requisite action against the negative attitudes that prevented them from developing and using newly learned interviewing skills. (2) Nine residents made *minimal* progress concerning negative attitudes; their interviewing skills improved significantly. (3) Twenty-three made *average* self-awareness progress and showed a greater increment of improvement in interviewing skills. (4) Twelve made *superior* progress in acting upon newly developing personal awareness that produced still better acquisition and use of interviewing skills. (5) Finally, three residents were classified as *not requiring* self-awareness work to improve their rapidly evolving superior interviewing skills.

1. Self-awareness training failures. We spotted the six residents in this category early by their failure to effectively deploy basic interviewing skills with real patients as well as by their aversion to self-awareness work.[14] While they were sometimes minimally aware of their resistance (e.g., that they were controlling), these residents were unable to assimilate or act upon feedback. We easily recognized the three excessively controlling failures by their rigid, intellectual, non-emotional, and often insensitive behaviors. The two passive-aggressive failures, however, were not apparent until after five or six sessions, when they, for example, repeatedly failed to find patients for interviewing exercises. Inability to form relationships with teachers or other residents was soon apparent also.

We continued trying to teach the basic skills, careful not to embarrass these residents in front of their often rapidly-progressing peers. We supported them by emphasizing their strengths and trying to engage them in some of the intellectual aspects of interviewing. At times, with domineering residents, we had to curtail their proclivity to take control, especially with unrelated material (e.g., philosophical or ethical discussions). The key for us as teachers was to avoid becoming frustrated, to support the residents, and to try to establish relationships. It was essential that we not get caught up in our own control and other issues[13]; frequent faculty discussions were our main tool for avoiding this.

Resident 1. *This young man, although always smiling and pleasant, was very rigid and resisted anything new. He pontificated, frequently lecturing other residents on how best to behave. His only betrayal of emotion was uncontrollable giggling during role play. In his attempts to perform patient-centered interviews with real patients, he faltered quickly and either turned to the instructor for help or began disease-oriented interviewing. He did not recognize or respond to feedback about negative, overly controlling behaviors during his interviews, and we eventually stopped asking him about self-awareness issues. Nonetheless, we stuck to the basics of interviewing and supported him by reinforcing his warmer side and establishing something of a relationship. We were pleased to see him, by the end of the rotation, using a few open-ended and emotion-handling skills with his patients.*

Self-awareness work is useful in spotting and addressing serious, pressing psychological problems such as depression and suicidal ideation.[13] We observed one "troubled" resident who was withdrawn and depressed, but did not try to work with that resident to resolve the issue. Rather, with the resident's permission, we promptly made a referral to a mental health professional.

2. Minimal self-awareness progress. There was no distinctive personality characteristic in this or any of the groups discussed below. Many of these residents were able to express emotions, and most had good relationships with teachers and others in the group. Virtually all were quite earnest and involved in learning and worked hard to improve skills and self-awareness. These nine residents showed effective basic interviewing skills with real patients by the end of the rotation.[17] They could open-endedly obtain the patient's story in its physical, personal, and emotional dimensions and address the emotions expressed. But, they lacked the ability to probe stories deeply, to stay with painful emotions, and to fully open themselves to a therapeutic relationship with patients.

These problems appeared to result from a lack of full awareness of the negative attitudes that interfered with using the skills, e.g., fears that patient-centered interviewing would upset patients, that it would harm patients, and that it might create too close a relationship for comfort. We worked on both skills and self-awareness with respect to these and other interfering attitudes. Residents in this group developed some awareness of their negative attitudes, such as their aversion to emotions and their impression that emotion-handling skills seemed "phony," but they never became confident—this restricted their use of the requisite patient-centered skills.

Resident 2. *This boastful man interacted seductively with women during interviews. On one occasion, his flirtatious and overly familiar behavior with a female patient (a prostitute) resulted in her reciprocating, which led to a clearly inappropriate relationship. Similar behavior with another patient led to her immediate distancing herself from him. The resident himself recalled that a mother had once reported him to the program director for being too familiar with her teenage daughter. He easily developed basic interviewing skills but had trouble staying with emotions and using emotion-handling skills, especially with women. He did, however, respond well to feedback and developed significant self-understanding about his need to change the way he interacted with women. We used role play to help him learn new, more professional behaviors and, following the rotation, he had no further problems interacting with women patients.*

3. Average self-awareness progress. These 23 residents exhibited good basic skills with patients and by the end of the rotation could, to some extent, probe the depths of their patients' stories and emotions. They expressed emotions and most had good relationships with teachers and others in the group. This group also exhibited greater self-awareness of negative attitudes towards interviewing. These residents had no sudden insights but, rather, slow, steady improvements in awareness over time. While role play continued to be useful, discussing emotional responses and behaviors benefited this group more than it had the preceding group. Unlike the groups discussed above, these residents were often very interested in their own personal processes, although they were occasionally anxious and frequently amazed that previously unrecognized attitudes had caused them considerable difficulty, not only with many previous patients, but in their personal lives as well. They developed significant self-awareness of negative attitudes such as lack of assertiveness, fear of discussing death, and anxiety about giving bad news.

Resident 3a. *An energetic young female resident was obsessive and impatient. She expressed fear of closeness because of potential subsequent losses. During two early interviews, she repeatedly avoided patients' references to death and, during discussions, she told us of her fear and anxiety*

about death, which she related to illness in the family during her childhood. By working to become self-aware of this previously unrecognized fear (as well as the fear of being intrusive, of causing harm, and of getting too close to the patient), and with support from teachers and the group, the resident was able to change this pattern of avoidance and, simultaneously, to become more emotionally expressive. She progressed significantly, becoming able to probe quite deeply into patients' stories and emotions, including those around death and other previously avoided, painful issues. The resident was herself only somewhat pleased with this outcome; she began feeling somewhat down once she was exposed to the extent of her patients' suffering. Indeed, one day she asked for a break, saying tensely, "I can't take this today." We worked further with this issue, supported her, and helped her develop distancing strategies when she began feeling overwhelmed.

Resident 3b. *A young resident, who initially disliked the rotation, was rigid and argumentative, but related well to other residents and teachers. She disdained patients' weaknesses and the whole psychosocial domain. There was, however, a warmth to her, and she engaged quite well when not arguing. She acknowledged having low self esteem; which she attributed to a problematic childhood. She seemed to understand that her attitudes were related to anxiety about lack of control. Considering her at first to be a member of the minimal-self-awareness group, we supported her, met her at the intellectual level, and did not criticize her beliefs. To our surprise, she began using newly learned interpersonal skills not only with patients but also with other group members, a propitious sign. Although she never gave up her opinions, she stopped arguing for the most part and, when she'd catch herself, would stop, apologize, and jokingly say, "There I go again." She also showed much interest in the group and related quite well to the teachers. We believed that the latter, rather than just the awareness of her attitudes, was a key ingredient in this striking turnaround.*

4. Superior self-awareness progress. This group of 12 residents differed from their peers, in that they were more comfortable with self-awareness work and were more open to trying new things in the interview, where their progress was greater and occurred more rapidly. While, like the other groups, they had unrecognized attitudes, they more easily recognized and addressed their negative attitudes. Because their self-awareness work went easily, and because we didn't keep pushing to greater depths (as is done in psychotherapy), these residents spent more time developing advanced interviewing skills. All became superb interviewers, with the capacity to develop full biopsychosocial stories about their patients, often by the second week of the rotation.

Resident 4. *A resident became quite skilled not only at interviewing but at supporting patients with severe, incurable problems. He initially exhibited frustration in interviewing these patients because he "could do nothing." Interviewing them made him feel intrusive, harmful, and helpless, which prompted him to avoid the deeper discussions these patients wanted. He rather animatedly said that patients "could not protect themselves" from someone probing their personal story, that they might "unravel." After considerable exploration, he realized that patients were much stronger and could indeed take care of themselves. In turn, he stated that there was value in simply being with patients and supporting them. Several dying patients said just that to him after we encouraged him to ask the patients about his impact.*

5. Superior interviewing progress without requiring self-awareness work. We observed three residents with few or no negative attitudes towards learning and using the skills and who learned to deploy them as effectively as the preceding group. These residents also were emotionally expressive, related well to other residents and teachers, and were quite mature. Upon repeated inquiry, we found no previously unrecognized responses that might interfere, although we did learn important personal material that helped with the teaching. We noted some minor resistances (e.g., feeling that addressing emotions is intrusive or harmful), but after one or two sessions of feedback, the residents resolved those attitudes. We noted no untoward behaviors suggesting self-awareness problems during many observed interviews.

Resident 5. *A mature, if controlling, young man had no prior interviewing training, but quickly learned the skills and performed advanced interviewing easily. In getting to know him, we learned of his strong spiritual orientation. He recognized and readily expressed a fear that "talking about God is not medical," and that discussing spiritual issues with patients would be discouraged as "inappropriate." He was pleased when we encouraged him to address the spiritual aspects of his patients. We elicited no pervasive negative attitudes, and he showed no resistance to learning and using patient-centered interviewing skills.*

Discussion

This study showed that, while most residents had unrecognized negative attitudes that interfered with their learning basic patient-centered interviewing, they were also able to develop awareness of those attitudes and, by acting on that new awareness, improve their interviewing skills. Successful self-awareness work closely paralleled successful skills work. We believe that the three residents who required no self-awareness training simply had greater psychological maturity in this area. The same can be said for the rapidly-progressing superior group. We suggest level of psychological maturity as a key determi-

nant of learning patient-centered interviewing skills.

How trustworthy are our data?[29] Their similarity to data from previous work[10,11,19] suggests that they are confirmable, dependable, and credible. In particular, Lyles' detailed evaluation of residents several years following this training program (with a different group of residents) provides strong supporting evidence, from residents' perspectives, for our findings.[19] Residents in that study reported that the training had enhanced their self-awareness and, in turn, their communication and relational skills—and that the impact had persisted. Our results are also consistent with experiences in psychiatry.[30] Nevertheless, while acknowledging other conceptual approaches,[31] we view this as a hypothesis-generating study and believe a hypothesis-testing quantitative study will be needed before the above findings can be generalized. Specifically, we hypothesize that skill training supplemented by self-awareness training will produce better interviewing skills and patient outcomes than will training in skills alone.

This rare systematic study of self-awareness in medicine suggests that teachers should supplement skill training by helping learners to become self-aware of resistive attitudes.[13] For example, when learners first interact with sufferers of chronic pain, a group of patients that physicians almost invariably dislike, teachers can productively explore the learners' negative emotions and behaviors. They can open the learners' eyes to how these incompletely recognized attitudes limit their effectiveness as physicians.

Another implication exists for teachers. Upon observing a problem with an interview, the teacher must resolve one fundamental question: is the problem due to a deficiency in a skill, resistance to using the skill, or both?[13] We recommend beginning self-awareness work after learners show initial mastery of the basic patient-centered skills,[17] usually after two or three sessions. This step minimizes the possibility of a deficiency in skills alone being the cause of problems with interviewing.

Educators seldom address it, but there is nothing new about valuing self-awareness. The famous inscription on the temple of Apollo at Delphi presaged us by centuries: "Know yourself." By integrating this ancient wisdom into our teaching, we can expect improved communication and provider–patient relationships to follow.

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