Unrecognized Responses and Feelings of Residents And Fellows During Interviews of Patients

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Physicians and medical educators believe that the physician-patient relationship is central to the practice of medicine, whether viewed from the scientific (1) or humanistic (2) perspective. In addition, one certifying board has recently required that candidates demonstrate competence in this interaction before they are eligible for board examinations (3). During the past several years, there has been an increase in teaching aimed at improving the physician-patient relationship, almost always in conjunction with teaching the medical interview. Because of time constraints, such teaching has been primarily designed to promote learning at the cognitive level, and some short-term success has been reported (4). There has been concern, however, that the medical trainees do not always use this newly acquired cognitive knowledge (5, 6). Thus, a physician-patient relationship and an interview can be rated poor even though the trainee is known to understand techniques that enhance both (5).

Unconscious, unrecognized responses of a trainee to a patient may explain this failure to use newly acquired knowledge on interviewing (5, 7, 8). Because a trainee may not recognize his long-ingrained feelings and behaviors, they can interfere with his use of newly learned cognitive knowledge that is in conflict with them. For example, a trainee's unrecognized fears of losing control may lead him to use over-controlling behaviors with the patient, although the student cognitively understands the importance of yielding control to the patient. Such unrecognized responses thus are important because they can detract from the physician's relationship with the patient and from the quality of information obtained in the interview (2, 9). To correct these unrecognized reactions, the trainee must become aware of the feeling and the behavior they provoke and must replace these behaviors with responses that improve the relationship with the patient (5, 7, 8). Neither becoming aware of the feelings and behaviors nor replacing these behaviors is easily accomplished, although success can be achieved (5).

The aim of the evaluation reported here was to determine the frequency of such unrecognized responses in 19 residents and fellows during a single interview of a patient.

Methods

The 19 participants, of whom 11 were men, ranged in age from 25 to 37 years; all were Caucasian. These residents and fellows were in family practice, internal medicine, and psychiatry programs at the University of Rochester Medical Center during the 1983-84 academic year. All were involved in primary care and were taking required work to learn about the psychosocial dimensions of medicine and the medical interview. The author supervised this work and directly observed each trainee's interaction with patients, some of which were with their own clinic patients. All were experienced in medical interviewing and had been observed by the author to have adequate basic interviewing techniques. One stated objective of the training session was for the residents and the fellows to become aware of previously unrecognized reactions to the patient and to understand how such reactions may affect the patient. The trainees understood that their own feelings during a patient encounter would be addressed. The author observed each trainee conducting a 30-to-45-minute interview to obtain a patient's history of the present illness in its psychosocial and biological dimensions. The author then conducted a 30-minute, open-ended evaluation of each trainee

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with a focus upon the trainee's feelings and behaviors in the interview.

While observing the interview, the author recorded the trainee's unconscious, unrecognized responses to the patient. Specific responses and behaviors were defined beforehand for rating in the following categories: avoidance of certain topics (such as death, disability, and loneliness), controlling the patient (inappropriately interrupting, changing the subject, directing the interview), passivity (failure to be in control of the interview), attempts to be pleasing (overly reassuring, making the interview pleasant, overly social), detachment (aloof, uninterested, avoiding relating to the patient), lack of respect and sensitivity (rude, brash, self-serving), seductiveness (overt expressions), and miscellaneous (all other unrecognized behaviors). To be considered as unrecognized behaviors, these responses could not be due to lack of proficiency with basic interviewing technique, and the trainee, as determined during the postinterview evaluation, could not be fully aware of them. Both the author and the trainee had to agree that the response was unrecognized. Typically, an unrecognized behavior was noted when an unexpectedly poor interview was observed, when the trainee failed to use skills he was known to possess, and when unexpected shifts in the interview occurred.

The postinterview evaluation was designed to confirm with the trainee the unrecognized behaviors and to determine "unrecognized feelings," that is, feelings the trainee had not been consciously aware of during the patient interview. These feelings were defined beforehand and rated in the following categories: fear of causing harm, fear of unpleasant topics, fear of loss of control, fear of affect, disdain, feeling intimidated, feeling inadequate, performance anxiety, biomedical attitude, identification with the patient, and feelings unique to the trainee. Again, both the trainee and the author had to agree that this underlying feeling was unrecognized.

Results

An unrecognized behavior in the patient interview was experienced by 16 of the 19 residents and fellows. Although more than one type of unrecognized behavior were often present, the most frequent behaviors were avoidance of difficult topics and passivity. Detachment, over-control, and overly pleasing behaviors were also prominent. All of the 16 trainees with unrecognized behaviors had unrecognized feelings that appeared to be related to the behaviors. That is, the feeling appeared to be the motivating force for the observed behavior. All of the defined categories of feelings were present among the 16 trainees, but anxieties about causing harm to the patient, addressing unpleasant topics, and losing control were most prominent. Feelings of inadequacy and identification with the patient were also frequent. In no instance was the trainee aware of either the feelings or associated behaviors. As the trainees discussed these newly identified, previously unrecognized responses, they realized that they had had similar difficulties in other situations involving patients.

Discussion

The study reported here demonstrated a high frequency of unrecognized responses among the residents and fellows studied. This finding was consistent with the author's earlier findings among medical students (5) and with the impressions of others that such unrecognized responses are common (2, 7, 10). Additionally, the specific findings of unrecognized desires to control patients and fears of harming patients have been reported before (10, 11).

The present report reflects the author's attempt to systematize observations made during the course of a medical interview. The lack of ratings by someone other than the author and the absence of a direct evaluation of the trainee's effect upon the patient are obvious shortcomings in the study. Nonetheless, information about the frequency and specific manifestations of the problem of unrecognized behaviors may be of value to those who teach medical interviewing. Specifically, when medical trainees who know basic interviewing techniques perform poorly, the author's observations indicate that it is insufficient to redirect teaching efforts toward technique alone (5). Rather, the poor performance is often a signal that unrecognized feelings are provoking the poor performance and that, to improve

the interview, the trainee must be made aware of these feelings and begin to address them.

The findings also indicate the need for medical educators to teach awareness and management of emotional responses to patients, most likely as part of teaching interviewing. Although it is beyond the scope of the present paper to consider specific teaching methods, the author considers that the findings strongly suggest a need to develop and implement better teaching strategies.

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