PERSPECTIVES

Teaching Personal Awareness

Robert C. Smith, MD, ScM,[1] Francesca C. Dwamena, MD,[1] Auguste H. Fortin VI, MD, MPH[2]
[1]Department of General Internal Medicine, College of Human Medicine, Michigan State University, East Lansing, MI, USA; [2]Yale University School of Medicine, New Haven, CT, USA.

Educators rarely consider the attitudes that determine whether a learner will use the clinical skills we teach. Nevertheless, many learners and practitioners exhibit negative attitudes that can impede the use of patient-centered skills, leading to an isolated focus upon disease and impairing the provider-patient relationship. The problem is compounded because these attitudes often are incompletely recognized by learners and therefore are difficult to change without help.

We present a research-based method for teaching personal awareness of unrecognized and often harmful attitudes. We propose that primary care clinicians without mental health training can follow this method to teach students, residents, faculty, and practitioners. Such teachers/mentors need to possess an abiding interest in the personal dimension, patience with a slowly evolving process of awareness, and the ability to establish strong, ongoing relationships with learners. Personal awareness teaching may occur during instruction in basic interviewing skills but works best if systematically incorporated throughout training.

KEY WORDS: self-awareness; countertransference; attitudes; provider-patient relationship; communication; medical education.
DOI: 10.1111/j.1525-1497.2005.40212.x
J GEN INTERN MED 2005; 20:201–207.

The formal curriculum of medical education has traditionally focused on teaching knowledge and skills, while attitudes often have been shaped by the "hidden curriculum."[1] The attitudes that determine a learner's willingness to learn and use skills are seldom formally taught.[2–16] This may occur, in part, because the attitudes and the closely associated thoughts and emotions that govern skill usage often are incompletely recognized by the learner and therefore can be difficult to change.[3,17]

Although limited, research does demonstrate that hidden feelings and attitudes harmful to patients are commonly exhibited during doctor-patient interactions, especially avoiding the patient's personal issues.[2,18] Thirteen of 15 sophomore medical students[5] and 16 of 19 residents and fellows[6] exhibited potentially harmful responses when observed in a single interview each. Table 1 lists their feelings and the resulting potentially deleterious behaviors. For example, fear of addressing psychological issues led a resident to overcontrol the interview and to inappropriately interrupt. Consider the life-threatening impact of avoiding data about suicidal intent as well as the harmful effect of these behaviors on communication and the relationship itself. These negative physician reactions do not diminish with age or experience. A study of board-certified physicians with an average age of 50 years showed that these doctors continued to exhibit potentially deleterious responses, particularly when threats to their integrity or self-esteem occurred.[19]

The rationale and approach for the method we present are modeled upon teaching personal awareness to psychiatry trainees.[11,12] Such work originates conceptually from the Freudian, post-Freudian, and person-centered domains where the methods are used to elicit, respond to, and teach about unconscious processes.[20–24] For teachers without mental health training, we have adapted these methods to provide teaching guidelines.[16,25–28] In accord with these precepts, our focus is improved awareness of personal issues as they relate to education and the patient rather than attempting psychotherapy and seeking wide-ranging personal change.[11,12]

Influenced and informed by research[8–10,29] and by other key recommendations,[2,7,14,18,30,31] the method presented here stems from our own research[3,5,6,19,25,32] and other teaching experiences[4,17,33–36] with primary care trainees. This method was evaluated during a 1-month, full-time course for postgraduate year 1 (PGY1) residents in medical interviewing and other aspects of psychosocial medicine.[3,25,32] Qualitative study demonstrated that it was effective.[3] Fifty out of 53 residents had negative reactions that interfered with learning patient-centered interviewing.[3,25] Using the method presented here, 44 of 50 residents changed their negative reactions and improved their communication and relationship skills—and thus better addressed patients' personal and emotional lives.[3]

THE METHOD

Overview

Teaching personal awareness (of incompletely recognized attitudes, emotions, behaviors, and thoughts) often occurs while teaching interviewing skills, but the same principles apply in other venues where patient interactions are evaluated, such as supervising residents' and students' inpatient activities, precepting in a clinic, and reviewing audio/videotaped interactions. We usually defer personal awareness work until learners show some mastery of the skills and knowledge base required for whatever course, activity, or rotation is occurring. Early on, we usually devote no more than 1 to 2 minutes at each critique of an interaction to a learner's personal awareness. Later, however, we can increase our focus on self-awareness to about 5 to 10 minutes at each critique of interactions with patients.

Always, upon recognizing a problem in a learner's interaction, the teacher asks and resolves one fundamental question: is this a skills deficiency, unrecognized resistance to using the skills, or both?[3] In Table 2, see Part #1 of an actual teaching vignette that illustrates the teaching of personal awareness.

Accepted for publication July 1, 2004

The authors are aware of no conflicts of interest.

Address correspondence and requests for reprints to Dr. Smith: B312 Clinical Center, 138 Service Road, Michigan State University, East Lansing, MI 48824 (e-mail: Robert.Smith@HT.msu.edu).

Table 1. Unrecognized Feelings and Resulting Behaviors in Students, Residents, and Fellows During One Interview*

Unrecognized *Feelings* Elicited Immediately After a Patient Interview	Unrecognized *Behaviors* Observed During a Patient Interview
Common	**Common**
1. Fears of losing control, addressing psychological material, appearing unpleasant, and harming the patient	1. Overcontrol of the patient and the interview, e.g., inappropriately interrupting the patient or changing the subject
2. Unique personal issues, e.g., reminds one of own difficult divorce, fear of cancer in self	2. Avoidance of psychological material, e.g., death, loneliness, disability
3. Performance anxiety	3. Superficial behavior, e.g., overly reassuring, overly social, cocktail party atmosphere
	4. Passivity, e.g., no control or direction, inactive, detachment
Uncommon	**Uncommon**
1. Sexual feelings	1. Seductiveness
2. Attitude favoring biomedical data	2. Critical, intimidating, passive-aggressive
3. Anger	3. Lack of respect and sensitivity
4. Fear of involvement	4. Withdrawal, distancing
5. Intimidation by patient	5. Awkward interactions
6. Inadequacy	
7. Disdain	
8. Identification with patient	

These data were obtained by one of the authors (RCS) during and following training interviews.[5,6] The author personally observed the learner-patient interview and noted untoward behaviors that were potentially unrecognized behaviors. The teaching critique followed immediately and always was begun with open-ended inquiry. This produced data about the learner's emotional response to the patient and also provided the data showing whether the interviewer was fully aware of the behaviors observed by the author. When the interviewer previously was fully aware of the emotions or behaviors discussed with the author, they were not included; i.e., only incompletely recognized emotions and behaviors are recorded here. Adapted from Smith.[36]

Personal Awareness as the Learner's Objective

The goal is to identify potentially harmful responses and, in turn, to facilitate learners' desire to work to change them. Students will learn about their previously unrecognized responses only if such awareness is their own objective.[37] To encourage this, teachers review the frequent adverse impact of physicians, residents, and students on patients (see Table 1) and point out that harm can be ameliorated by developing an awareness of the unrecognized emotions, attitudes, thoughts, and behaviors that cause it.[3] If these concepts are presented in a safe, caring, sensitive, and noncoercive way, most learners are eager to participate; that is, we achieve buy-in. To increase interest in awareness of one's own fears, frustrations, and other emotions, we can ask learners to tell about difficult patients or other medical circumstances.

Recognize Previously Unrecognized Responses

Early Work: Raise Learners' Emotional Responses to Full Awareness and Facilitate Recognition of Their Behavioral Consequences. After observing interviews and clinical encounters or after reviewing audio/videotapes, we reinforce the primacy of emotions by addressing them first in a critique; for example, "So, before we look at the interaction, how'd that go for you?" is a good open-ended beginning. The teacher gradually becomes more active and focuses on emotions; for example, "How'd that make you feel when the patient talked all the time?"

Self-disclosure by the instructor is a powerful facilitating tool for learners reluctant to share feelings[38]; for example, "I was feeling irritated with all that talking." Teachers also may help students or residents to express feelings by asking how they "liked the patient" or how it felt to be watched or videotaped. Raising emotional responses to full awareness is the first task for personal awareness work.

The instructor continues to focus open-endedly on the learner's emotions and handles the emotion with empathic responses;[34,39] for example, "That was embarrassing for you and I can sure understand." As with eliciting the "patient's story," open-ended inquiry alternating with emotion seeking and emotion handling is necessary to develop the "learner's story."

Teachers also help the student realize that the feelings she/he experienced will have behavioral consequences; for example, "How might your fear of losing control affect your behavior with the patient?" On the other hand, while critiquing the interview or other interaction, the instructor may identify a problematic behavior before identifying the underlying emotion. If the student or resident does not mention any difficulty or problem, usually because she/he is unaware of it, the teacher can describe the untoward behavior and discuss it with them. If available, it helps to get outside corroboration from observers or to replay a tape to assist the learner in appreciating that a problematic behavior existed; for example, overcontrolling, superficial, avoiding material the patient raises. Then the teacher can seek the underlying emotion, using gentle open-ended inquiry; for example, "You and the group agree, you were taking over from the patient. What were you feeling at the time, you know, emotionally?" Recalling that this is a new experience, the teacher monitors the learner's response to inquiry. Like patients, learners will convey how quickly and how far they want to go into the emotional realm.[38]

See Table 2 for Part #2 of the vignette.

Later Work: Facilitate Learner's Understanding of the Origin and Scope of Newly Recognized Responses. The teacher tries to discover just how unrecognized and how pervasive problematic emotions and behaviors have been. For example, she/he might ask, "Does this response (e.g., avoiding painful topics, controlling) occur anywhere else in your life?" or "Where does that come from in your past, you know, where'd you learn it?" Typically, students and residents will recognize its presence and its adverse impact in many other areas—with other patients and in their personal lives. They also realize that they had not been fully aware of this feeling, attitude, or thought and its resultant behavior.

Table 2. Vignette Illustrating the Teaching of Personal Awareness

Part #1

A 25-year-old sophomore medical student demonstrated his high level of proficiency with patient-centered skills in an earlier interview. Reviewing a videotape in which the objectives were to perform the patient-centered interview, the 38-year-old instructor (a primary care clinician) noted that the student ignored his patient's four references to marital problems and obtained no personal data whatsoever. To her surprise, the student spent less than 2 minutes being patient centered and then began the doctor-centered process concerning the patient's sore throat.

Open-ended inquiry (by the teacher) about the interview showed that the student was not aware of his avoidant behavior. He said only that he "didn't get much" and that the patient "wasn't very open." He acknowledged no personal emotional reaction. The instructor realized that simply readdressing basic skills would not suffice.

Part #2

(Continuing in the same teaching session described in Part #1)

The instructor wondered whether the student himself was having trouble in a relationship, but realized she needed data to evaluate this. After hearing that the student liked his patient, the instructor respectfully observed that he had avoided several references to marital problems. The student agreed with her observation, explaining that addressing the patient's marriage would have been harmful. He went on, prompted by the teacher's open-ended facilitation ("So, why's that?"), to say how much his brother's recent divorce had bothered him and how hurt his brother had been. As she continued open-ended facilitation, he admitted to being depressed when his parents had divorced many years ago, and being "very down" for about a month after his own temporary break-up with his fiancée one year earlier. He laughingly said, "I guess you can't trust women." After being supportive, the teacher and the group encouraged the student to consider staying with issues around marital discord as an objective for the future. He was appreciative of the attention, but signaled the end by saying, "That's enough of me. Let's hear somebody else's dirty laundry." Given time constraints, other students' needs, and good self-awareness progress, the teacher again supported his hard work and candor and addressed a specific skills issue she had noted.

In the meantime, trying to be aware herself, the teacher noted her own discomfort addressing the student's relationship with his fiancée and his comments about not trusting women. She wanted to be certain that her reactions did not interfere with effective teaching. She suspected the student also was asking whether she could be trusted with his feelings.

Part #3

A few sessions later, another videotape of the same student was reviewed. A 45-year-old patient with irritable bowel syndrome frequently described her concern about her husband's imminent death from cancer. The student again ignored these comments and focused on issues the patient initially raised about job security.

When the teacher inquired, the student said that he had heard some concern about death issues. Yet the student still claimed that the patient "didn't want to discuss" death and that to do so was "prying" anyway. With skillful facilitation, the student further indicated that he was reminded of his beloved grandfather's death many years ago, going on to say he "didn't like death any better than divorce. I just like people without bad problems." The teacher then noted that the student had told of avoiding these "bad" issues elsewhere, even with his fiancée when he refused to discuss her concerns about their relationship. After the teacher and group indicated that they thought the patient wanted to discuss death issues and that to do so was not intrusive, the student agreed that his behaviors and emotions were not realistic and perhaps were harmful. He thanked the group for their help and specifically thanked the teacher for her "interest."

Part #4

In a later session, the teacher ascertained that the student would like to change his avoidant behavior around topics of death and divorce. Supporting his courage and indicating that he seemed ready for change, the teacher suggested role playing. The student actively worked with a dying patient in role play. This was particularly effective when the student in the patient role gave feedback about how much better it felt to have the issue addressed. Nevertheless, the student still experienced difficulty and some anxiety, saying "It's as though everything's going to be gone." After support from the group and teacher for his efforts, he began to realize that these were "old patterns" he was replacing with healthier new ones. He thanked the group and commented, "This isn't so bad after all."

The teacher believed the student was making good progress and planned to facilitate his awareness of these separation issues. Because the student had become quite involved in the group, its imminent ending could also provide a focus for this work.

Part #5

For the student's last interview of the block, he was successful in addressing the death concerns of a dying patient. He was surprised that he was able to do it and that it was not as hard as he had expected. "It's like I've been afraid of this all my life and I didn't need to be," he exclaimed. The teacher predicted that death issues would continue to pose problems and that identifying this as an Achilles' heel would help him stay aware and allow his continued progress. The student reported that he had begun to address some painful issues around separation with his fiancée and that he was surprised that she seemed to want to discuss them. He realized that it was not she but he who had avoided them before.

At the end of this final session, the student indicated how good he had felt in the group and that openly saying goodbye was part of what he was working on in his journal, addressing painful issues around separation. He said the teacher "seemed different, somehow" and that he liked that because he had not expected to like her at the beginning of the course.

The teacher was pleased with this outcome, relieved that no conflict had developed, and believed that the student had made significant progress with personal self-awareness—but that continued work was in order.

Some learners will share emotions about their personal lives. It is appropriate to address personal issues, to the extent comfortable to teacher and learner, because it helps them realize how extensive and pervasive unrecognized emotions and attitudes can be. On the other hand, teachers do not attempt psychotherapy (even if trained to do so) and do not allow personal issues to dominate the teaching. Our focus is linking personal work to the patient and to the training during no more than 5 to 10 minutes of awareness work.[11,12,40]

Learners also may have feelings about the teacher. When positive, these are acknowledged and bode well; for example, "Thanks for saying that, I appreciate the feedback." When reactions are negative, teachers foster exploration, address them openly and candidly, and negotiate solutions. Unresolved, negative reactions will become an impediment to the work that depends, above all, upon a positive teacher-learner relationship.[38]

Teachers actively involve other students if working in a group situation. Others may be uncomfortable observing this work with a peer and they may be fearful for what is about to happen to them or think that the process is too intrusive; for example, "John's been sharing some important stuff, what's your reaction to all this?" The needs of the group usually take precedence over the needs of the individual.[38]

The teacher encourages a group's use of emotion-handling skills and giving constructive feedback to each other. In time, a group itself can do much of the personal awareness teaching.

The teacher models the proper use of feedback: understand where the learner is emotionally, know how prepared she/he is to hear feedback, give appropriate feedback about one or two specific behaviors, avoid general comments, give only a manageable amount of feedback, avoid criticism of the learner as a person, and balance corrective feedback with comments on what they did well.[41]

Determine Whether the Newly Recognized Responses Are Harmful or Helpful

After identifying previously unrecognized feelings and behaviors, the learner and teacher (and others if in a group) must decide whether these are harmful or helpful. *Harmful responses* are not congruent or commensurate with the patient's situation; that is, the student's response does not respond accurately to the patient's comments and behaviors and tends more to reflect the student's own internal process and unrecognized needs; in other words, it is the student's "own stuff." We seek to avoid these harmful responses to the patient and work with the learner to change them. *Helpful responses* accurately respond to the patient's circumstance and are reinforced by the teacher as having both diagnostic and therapeutic value in working with the patient. See Table 3 for the specific criteria to differentiate helpful from harmful responses.

Because this often is unexplored territory for the student, exploring the patient's reality must be actively facilitated; for example, "Now, let's look at how closely your response corresponds to the patient's situation." To guide this process, others in a group are asked to give their emotional responses to the patient, and the teacher shares her/his own. When the learner's response differs from that of group members, this suggests it is not reality based, especially when this response is common across many different patients. When feasible, it is valuable to ask about patients' responses to the interaction being critiqued. When the student's response missed the mark and did not meet the patient's needs, this is even better evidence (see Table 3).

To make this crucial determination of responding to the patient's reality, patient utterances and behaviors from the interaction are the focus.[36,42] One asks, for example, "What data are there that the patient didn't want to discuss death, and what data suggest that she/he did?" This reinforces our picture of the interview as a scientific instrument producing hard data about the subject of our science (the person) and our own scientific approach by evaluating only verifiable information.[36,42] An entire group can sometimes unconsciously collude in a distorted interpretation, and the teacher must favor data from the interaction over unanimous opinion. Corroborating information, though, sometimes must be sought in later interviews and patient interactions (and in a learner's interactions with others in the group).

When personal awareness work is successful, the student will identify the problematic response as harmful. Although facilitated by the teacher, this recognition must come from the resident or student. Teachers reinforce, praise, and support the new awareness; for example, "That's been a tough problem for you, and you've worked hard and really stuck your neck out. Nice work." We clearly label the response as a problem so that we can further address it; for example, "It helps us to work on your dislike of discussing death by identifying it as a personal trouble spot or Achilles' heel."

See Part #3 of the vignette in Table 2.

Change Harmful Responses That Do Not Mirror the Patient's Reality

Teachers continue to identify the harmful responses, improve understanding of their origin, and help the student develop healthier replacements. Better understanding occurs by addressing current personal issues, significant past family and other events, and the way in which the interviewer interacts with the teacher and others in the group; for example, the learner exhibits a pleasing behavior with patients, parents, and teacher—"I was brought up always to be pleasant and avoid painful subjects."

Although some harmful responses disappear just by identifying them, many do not. To change problematic responses, the teacher emphasizes the student's personal choice and responsibility; for example, "The choice is really up to you." The teacher can highlight the student's capacity for change, the

Table 3. Criteria for Harmful and Helpful Responses

Harmful Responses

1. The patient indicates their needs were not met.

   Sometimes a student avoids a patient's references to, for example, death and, during critique, claims that this avoidance was necessary to spare the patient, notwithstanding that the patient repeatedly mentioned death, indicating she/he did want to discuss it. Hearing the patient say, when asked later, that she/he was frustrated by not being able to discuss it is powerful, awareness-producing feedback. This helps the learner conclude that they were responding to their own fear (of death or of painful issues), and that they erroneously projected this fear onto the patient, thereby distorting the patient's reality.

2. The instructor and other observers did not experience the same emotional response.

   Another good reality check, if the observers agreed that the patient was not avoiding discussion of death, we would further suspect that the interviewer's response was her/his "own stuff" and not an accurate reflection of the patient.

3. Over time, the same response occurs with different patients, responses are intense, and they are self-centered.

   The above student might quite self-assuredly say essentially the same thing about many different patients who raise death issues.

Helpful Responses

1. The patient indicates her/his needs were met.
2. Observers experience the same response as the interviewer.
3. There is no stereotypic response to all patients, the response is other directed, and it is not intense.

   Consider an interviewer who experiences mild irritation while interviewing a patient who repeatedly takes a long time to develop a point and then negates it with more pertinent data. When these three "helpful criteria" are present, we can conclude that the interviewer's irritation was congruent, reality based, and a good indicator of the patient's situation. Such irritation is the learner's response to the patient's confusion, hesitancy, or passive-aggressive behavior. It can be of clinical value in diagnosing such conditions or behaviors (see text).

challenge inherent in the choice, and that the time is right; for example, "I like your energy and willingness to try something new. This likely will take some new, unexpected directions, and you'll have to stretch yourself a bit, but I think you're ready."[43]

On the other hand, trainees may recognize they cannot or do not want to change,[44] and they may benefit from support for that decision; for example, "Given your circumstances at home, it may be very difficult for you to do anything about this now. I agree that being more assertive could cause more troubles." Other measures to address the identified problem may be necessary; for example, an exercise program could be devised to ease the resident's tensions.

Role playing helps develop both insight and change. By playing the patient while the teacher or another student takes the learner's role, the learner experiences what her/his problematic behavior feels like as a patient. Students and residents should spend most of their time, however, role playing new and healthier behaviors—a safe and effective method to learn a new repertoire.[3] In both situations, feedback from the person playing the other role is essential. Role play also is a way to rehearse new behaviors for situations in daily life, such as using open-ended skills with a spouse.

After effective work in role play, one identifies specific behavioral objectives for subsequent patient encounters; for example, a resident who interrupts frequently can identify remaining silent for 10 seconds on three separate occasions during an interaction as a goal. It is best to limit these behavioral objectives to one or two items that focus on the most important problem and have the best chance for success. It also helps for learners to keep a journal with a log of objectives and specific behaviors they want to master and to record their responses to this work.

See Part #4 of the vignette in Table 2.

Encourage Helpful Responses That Mirror the Patient's Reality

Many congruent responses, those accurately responding to the patient's reality, reflect sensitive, caring dimensions of the resident or student, but they may be more difficult to detect because they are less intensely experienced; for example, feeling sad about a patient's biopsy report, caring about one's patient undergoing a painful divorce. Accurate, congruent responses usually are other directed and lack the self-centered intensity often seen with harmful responses. Because these responses reflect the patient's reality, some will have diagnostic value in identifying this reality, often providing clues to what might otherwise have been missed[45]; for example, when a student felt depressed (observers did also and this was not a stereotypic response of the student) after working with a certain patient, we recognized that the patient had subtle, unrecognized manifestations of depression. Low-grade sexual excitement can indicate a patient's subtle seductive behavior; minor irritation may be the clue to passive-aggressive behavior; and feeling helpless may identify a patient who is indeed feeling helpless.

Congruent responses also have therapeutic value.[45] In emotionally perceiving what the patient is truly experiencing, the interviewer becomes truly empathic, a central feature in maximizing the doctor-patient relationship and healing.[46] When a resident/student responds appropriately to these feelings, the relationship improves because the patient feels understood. In contrast to diagnostic use of congruent responses, therapeutic use often entails sharing one's response with the patient; for example, "You know, I'm feeling kind of down hearing this, how're you doing?"

Continue Personal Awareness Work over the Course of the Teaching

This work over time will encourage a strong relationship with the teacher and can lead to a mentoring relationship. It is appropriate toward the conclusion of a particular course or experience to encourage discussion of one's reactions to ending. The teacher and the learner(s) usually experience parting as a loss. At the last session, the individual learner or group can summarize behavioral objectives for continued work on their own, and give and receive final feedback.

Most students and residents become aware of previously unrecognized responses[3,4,7,11,12] and are able to make some changes after three to five critique sessions; for example, a resident's frequent interruptions markedly diminished after three sessions although other work remained to be done. Teachers often must focus on several behaviors at once; for example, working on being less controlling and not being afraid to use one's sensitive, caring responses.[5,6,26] One notes progress by observing the new behaviors and also by the learner's engagement with the process. Learners usually feel both mildly apprehensive and fascinated with their own personal process as new discoveries and changes occur. Successful learners enjoy doing the work, bring up new issues and expand old ones, and often show increased caring for patients and for the others in the group.

See Part #5 of the vignette in Table 2.

Could Teaching Personal Awareness Be Harmful?

We have used this method in four studies[3,5,6,26] and our other teaching, and we have observed no adverse impact on students, residents, and fellows. Nevertheless, one always is vigilant, particularly for subtle signs of depression, anxiety, and substance abuse.

To assure safety, we repeatedly address confidentiality, emphasizing that this work is not discussed with anyone else, nor is it discussed among group members outside specific meeting times. Learners also are advised that personal material will not be used as part of their evaluations, lest they be penalized for sharing, for example, negative thoughts and feelings about some aspects of their training program. The growth and development that occur with personal awareness work should happen without anxiety, depression, disruption of work or personal circumstances, or other adverse side effects. Nevertheless, learners sometimes will cry or otherwise become upset. We handle this like we do with patients: empathy, problem solving, ensuring a return to normal, and offering the option for further discussion (or not) now or later.

There are several situations that usually require mental health consultation for learners. 1) If the learner is depressed or severely anxious, immediate mental health consultation is needed. Even if trained, it is inappropriate for the teacher to treat the learner with, for example, counseling or medications. 2) Far less common, evidence of psychosis or personality disorder, dysfunction at home/work, untoward behaviors, or of

substance abuse, also dictates referral. 3) Similarly, the teacher may discover a severe problem that is refractory to personal awareness work and which the learner continues to deny as a problem (e.g., prominent hostility and insensitivity). The teacher and others must develop a plan to better meet the needs of the learner as well as her/his future patients. 4) Finally, when students wish to do more personal awareness work, one may refer for counseling or group work, a healthy outcome of the teaching.

Seemingly adverse outcomes are, in reality, successes of the teaching. Troubled and problem learners have been spotted early, and appropriate actions initiated. If available, a skilled mental health professional on the teaching team can help with assessment and provide emergency consultation. Otherwise, such a professional should be identified beforehand and readily accessible for curbside consultation, clinical assessment, and for the rare emergencies that occur. The program director, key faculty, and experienced colleagues will also be valuable allies and often need to be involved administratively if serious problems arise.

We have no research information on the potential for harm to teachers but, as with learners, we must monitor ourselves in these close teaching relationships for many of the same issues. Similarly, a coteacher with whom one discusses the teaching can help in identifying problematic issues—as well as in providing the support that helps allay and solve them. Certainly, all of the above danger signals apply to teachers as well and indicate the need for personal mental health consultation. In addition, we have observed that the following often are danger signals that could create significant anxiety and stress in the teacher. These require educational consultation from someone familiar with personal awareness work. 1) Recalling that the teaching should be enjoyable, persistent discomfort, dreading upcoming sessions, and intensely negative (or intensely positive) responses to learners warn of the teacher's personal difficulty. 2) Many students consistently giving negative responses and failing to develop personal awareness also suggest a problem and the need for consultation.

Teachers and Their Resources

Teaching personal awareness is not easy, but we have observed that teachers have experienced a new and wider dimension in their teaching. Not only were successes gratifying, but they also enjoyed the process of getting to know learners better—and, almost inevitably, learning more about themselves. Personal awareness, experience with the interviewing/interactional process, sensitivity to learners' needs, maturity, common sense, patience with the slowness of change, and the capacity to develop a relationship are essential. Training in counseling skills and group dynamics[38] can enhance the teacher's work. The American Academy on Physician and Patient (www.physicianpatient.org) has effective training programs for learning these skills as well as for developing one's own personal awareness. Support groups of other teachers and personal supervision of one's teaching by a psychologically trained colleague can also help our teaching skills. Similarly, formal training that includes these teaching approaches can lead to improvement.[47]

The Appendix (available online at http://www.blackwellpublishing.com/products/journals/suppmat/jgi/jgi40212/jgi40212.htm) provides an overview of several specific curricula for residents and students, their methods, and the procedures for implementing them. It also indicates that additional, more specific teaching resources are available upon request from the authors. Finally, it outlines how one might proceed through initial, early, and later sessions for teaching personal awareness.

Conclusion

This teaching method can provide the basics of a research-based technique for teaching personal awareness in this field where research is both difficult and rare. More qualitative study and rigorous, hypothesis-testing quantitative work will be needed before we can identify a truly evidence-based method. Nonetheless, the method we present provides an evidence-based beginning in an area that is key to improving physician-patient relationships.[3]

REFERENCES

1. **Hafferty FW.** Beyond curriculum reform: confronting medicine's hidden curriculum. Acad Med. 1998;73:403–7.
2. **Novack DH, Suchman AL, Clark W, Epstein RM, Najberg E, Kaplan C.** Calibrating the physician: personal awareness and effective patient care. JAMA. 1997;278:502–9.
3. **Smith RC, Dorsey AM, Lyles JS, Frankel RM.** Teaching self-awareness enhances learning about patient-centered interviewing. Acad Med. 1999;74:1242–8.
4. **Smith RC.** Use and management of physicians' feelings during the interview. In: Lipkin M, Putnam SM, Lazare A, eds. The Medical Interview. New York, NY: Springer-Verlag; 1995:104–9.
5. **Smith RC.** Teaching interviewing skills to medical students: the issue of 'countertransference'. J Med Educ. 1984;59:582–8.
6. **Smith RC.** Unrecognized responses by physicians during the interview. J Med Educ. 1986;61:982–4.
7. **Gorlin R, Zucker HD.** Physicians' reactions to patients: a key to teaching humanistic medicine. N Engl J Med. 1983;308:1059–63.
8. **Johnson AH.** Assessing counselling skills and attitudes in family practice. J Fam Pract. 1979;9:447–52.
9. **Schildkrout E.** Medical residents' difficulty in learning and utilizing a psychosocial perspective. J Med Educ. 1980;55:962–4.
10. **Sherer LM, Johnson AH.** Resident development in family practice training: a personal counselling program. J Fam Pract. 1980;10:1017–23.
11. **Ekstein R, Wallerstein RS.** The Teaching and Learning of Psychotherapy, 2nd ed. New York, NY: International Universities Press; 1972.
12. **Schuster DB, Sandt JJ, Thaler OF.** Clinical Supervision of the Psychiatric Resident. New York, NY: Brunner/Mazel; 1972.
13. **Smith RC, Marshall AA, Cohen-Cole SA.** The efficacy of intensive biopsychosocial teaching programs for residents: a review of the literature and guidelines for teaching. J Gen Intern Med. 1994;9:390–6.
14. **Palmer PJ.** Reflections on a Program for "The Formation of Teachers." An occasional paper of the Fetzer Institute, Kalamazoo, MI; 1992.
15. **Lipkin JM, Kaplan C, Clark W, Novack D.** Teaching medical interviewing: the Lipkin model. In: Lipkin M, Putnam SM, Lazare A, eds. The Medical Interview. New York, NY: Springer-Verlag; 1995:422–35.
16. **Marshall AA, Smith RC.** Physicians' emotional reactions to patients: recognizing and managing countertransference. Am J Gastroenterol. 1995;90:4–8.
17. **Smith RC.** Teaching Supplement for 'The Patient's Story—Integrated Patient-Doctor Interviewing'. B306 Clinical Center, Michigan State University, East Lansing, MI: Author; 1996.
18. **Novack DH, Epstein RM, Paulsen RH.** Toward creating physician-healers: fostering medical students' self-awareness, personal growth, and well-being. Acad Med. 1999;74:516–20.
19. **Smith RC, Zimny G.** Physicians' emotional reactions to patients. Psychosomatics. 1988;29:392–7.
20. **Mitchell SA.** Relational Concepts in Psychoanalysis—An Integration. Cambridge, MA: Harvard University Press; 1988.
21. **Mitchell SA.** Relationality. Hillsdale, NJ: The Analytic Press; 2000.
22. **Rogers CR.** On Becoming a Person. Boston, MA: Houghton-Mifflin; 1961.
23. **Rogers CR.** The characteristics of a helping relationship. Personnel and Guidance Journal. 1958;37:6–16.

24. **Rogers CR.** Client-centered Therapy. Boston, MA: Houghton Mifflin Company; 1951.
25. **Smith RC, Lyles JS, Mettler J, et al.** The effectiveness of intensive training for residents in interviewing. A randomized, controlled study. Ann Intern Med. 1998;128:118–26.
26. **Smith RC, Osborn G, Hoppe RB, et al.** Efficacy of a one-month training block in psychosocial medicine for residents: a controlled study. J Gen Intern Med. 1991;6:535–43.
27. **Smith RC, Mettler JA, Stoffelmayr BE, et al.** Improving residents' confidence in using psychosocial skills. J Gen Intern Med. 1995;10: 315–20.
28. **Smith RC, Lyles JS, Mettler JA, et al.** A strategy for improving patient satisfaction by the intensive training of residents in psychosocial medicine: a controlled, randomized study. Acad Med. 1995;70: 729–32.
29. **Hall JA, Roter DL, Milburn MA.** Illness and satisfaction with medical care. Curr Direct Psychol Sci. 1999;8:96–9.
30. **Palmer PJ.** The Courage to Teach: Exploring the Inner Landscape of a Teacher's Life. San Francisco, CA: Jossey-Bass; 1998.
31. **Williamson PR, Smith RC, Kern DE, et al.** The medical interview and psychosocial aspects of medicine: block curricula for residents. J Gen Intern Med. 1992;7:235–42.
32. **Smith RC, Marshall-Dorsey AA, Osborn GG, et al.** Evidence-based guidelines for teaching patient-centered interviewing. Patient Educ Couns. 2000;39:27–36.
33. **Fortin AH VI, Haeseler FD, Angoff N, et al.** Teaching pre-clinical medical students an integrated approach to medical interviewing—half-day workshops using actors. J Gen Intern Med. 2002;17:704–8.
34. **Fortin AH VI.** Communication skills to improve patient satisfaction and quality of care. Ethn Dis. 2002;12(suppl 3):58–61.
35. **Smith RC.** Videotape of Evidence-based Interviewing: 1) Patient-centered Interviewing and 2) Doctor-centered Interviewing. Available at: http://www.msuvmall.msu.edu/imc. Accessed February 27, 2004.
36. **Smith RC.** Patient-centered Interviewing: An Evidence-based Method, 2nd ed. Philadelphia, PA: Lippincott Williams and Wilkins; 2002.
37. **Knowles MS.** The Modern Practice of Adult Education: From Pedagogy to Andragogy. New York, NY: Cambridge, The Adult Education Company; 1980.
38. **Yalom ID.** The Theory and Practice of Group Psychotherapy, 3rd ed. New York, NY: Basic Books, Inc.; 1985.
39. **Shapiro J.** How do physicians teach empathy in the primary care setting? Acad Med. 2002;77:323–8.
40. **Balint M.** The Doctor, His Patient, and the Illness, Revised ed. New York, NY: International Universities Press; 1957.
41. **Ende J.** Feedback in clinical medical education. JAMA. 1983;250:777–81.
42. **Engel GL.** White coats, intimacy, and medicine as a human science. Presentation to the Program for Biopsychosocial Studies. The University of Rochester School of Medicine and Dentistry; Rochester, NY; June 3 1994.
43. **Miller WR, Rollnick S.** Motivational Interviewing: Preparing People for Change, 2nd ed. New York, NY: Guilford Press; 2002.
44. **Prochaska JO, DiClemente CC.** Stages of change in the modification of problem behaviors. Prog Behav Modif. 1992;28:183–218.
45. **Kernberg O.** Notes on countertransference. J Am Psychoanal Assoc. 1965;13:38–56.
46. **Matthews DA, Suchman AL, Branch WT.** Making "connexions": enhancing the therapeutic potential of patient-clinician relationships. Ann Intern Med. 1993;118:973–7.
47. **Cole KA, Barker LR, Kolodner K, Williamson P, Wright SM, Kern DE.** Faculty development in teaching skills: an intensive longitudinal model. Acad Med. 2004;79:469–80.
48. **Olson J, Kent K, Lein CE, Smith RC.** Role of resident attitudes in learning and using skills in patient-centered interviewing. Semin Med Pract. 2002;5:3–12.
49. **Scheingold L.** Balint work in England: lessons for American family medicine. J Fam Pract. 1988;26:315–20.
50. **Courtenay MJF.** A plain doctor's guide to Balint-work. J Balint Soc. 1992;20:20–1.