Calibrating the Physician

Personal Awareness and Effective Patient Care

Dennis H. Novack, MD; Anthony L. Suchman, MD; William Clark, MD; Ronald M. Epstein, MD; Eva Najberg, MSc; Craig Kaplan, MD; for the Working Group on Promoting Physician Personal Awareness, American Academy on Physician and Patient

Physicians' personal characteristics, their past experiences, values, attitudes, and biases can have important effects on communication with patients; being aware of these characteristics can enhance communication. Because medical training and continuing education programs rarely undertake an organized approach to promoting personal awareness, we propose a "curriculum" of 4 core topics for reflection and discussion. The topics are physicians' beliefs and attitudes, physicians' feelings and emotional responses in patient care, challenging clinical situations, and physician self-care. We present examples of organized activities that can promote physician personal awareness such as support groups, Balint groups, and discussions of meaningful experiences in medicine. Experience with these activities suggests that through enhancing personal awareness physicians can improve their clinical care and increase satisfaction with work, relationships, and themselves.

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HOWEVER WELL physicians have learned the science of medicine, they use themselves to practice its art. They can knowingly use certain skills to elicit a patient's story, work through a diagnosis, promote rapport, and influence patients' understanding, decision making, compliance, and emotional well-being.[1-9] Physicians' effectiveness in using these skills, though, depends on a variety of personal factors.[2,10-14]

Using their emotional resources and experiences,[2,15-20] physicians connect with patients and support them through myriad distressing situations. Physicians' personalities, personal histories, family and cultural backgrounds, values, biases, attitudes, and emotional "hot buttons" influence their reactions to patients. Unrecognized feelings and attitudes can adversely affect physician-patient communication: they may interfere with physicians' abilities to experience and convey accurate empathy[21]; may preclude or distort meaningful discussions with patients about dying, sexuality, and other difficult topics; or may lead to underinvolvement or overinvolvement with certain patients.[22] Unacknowledged needs can "leak" inappropriately during the medical encounter and endanger the physician-patient relationship.[23]

Because physicians use themselves as instruments of diagnosis and therapy,[1,2,24] personal awareness can help them to "calibrate their instruments," using themselves more effectively in these capacities. We define physician personal awareness as "insight into how one's life experiences and emotional make-up affect one's interactions with patients, families, and other professionals." Physicians can increase their personal awareness through a variety of approaches. Most involve reflection about past and present experiences, in solitude or with others, and often require time set aside from the usually hectic pace of training or work life.

Mental health professionals, whose work demands use of "self" to assist patients in emotional pain, participate in reflective educational experiences. Effective therapists monitor their emotional responses to inform the therapeutic process for their patients' benefit. Because medical practitioners routinely work with patients in emotional pain, frequently discuss sensitive issues, and counsel people experiencing minor and major stressors, it would seem essential that they have similar training.

Some writers have stressed the importance of activities that promote personal awareness in medical education,[25,26] noting that improved awareness facilitates healing relationships with patients[22,27] and coping with stress.[28] Others have emphasized the value of support groups in promoting personal and professional growth, as well as physician mental health.[29] Physicians who become more aware of the influences of personal factors on their behaviors can better examine how and why they make behavioral choices. Their choices can become more informed and potentially more free. Personal awareness can be a first step in stimulating adaptive attitudinal and behavioral changes. It can also lead to a deeper and more sophisticated understanding of patients' behaviors.

Yet medical school and residency curricula often do not include these activi-

From the Division of Medical Education, MCP-Hahnemann School of Medicine, Allegheny University of the Health Sciences, Philadelphia, Pa (Dr Novack); University of Rochester School of Medicine and Dentistry, Rochester, NY (Drs Suchman, Epstein, and Kaplan); Addiction Resource Center, Midcoast Hospital, Bath, Me (Dr Clark), and Saint Bartholomew's and the Royal London School of Medicine and Dentistry, London, United Kingdom (Dr Najberg).

Additional participants in the Working Group on Promoting Physician Personal Awareness are listed at the end of this article.

Reprints: Dennis H. Novack, MD, Division of Medical Education, MCP-Hahnemann School of Medicine, Allegheny University of the Health Sciences, 2900 Queen Lane, Philadelphia, PA 19129.

ties.[30,31] Worse, some aspects of medical education promote self-defeating attitudes and behaviors[32-37] that may hinder the development of trainee personal awareness. Practicing physicians, frustrated by certain patients or aspects of their practices and occasionally stressed to the point of burnout,[38] might benefit from enriching their awareness in interactions with patients and colleagues.[28] However, we know of only a few organized community activities or medical conferences with a personal awareness focus.

Our interest in physician personal awareness derives from 2 activities. Since 1983, we have participated in faculty development courses sponsored by the American Academy on Physician and Patient (AAPP, formerly the Task Force on the Medical Interview of the Society of General Internal Medicine). The AAPP courses, aimed at improving interpersonal skills in teaching and practice, include discussion groups on personal awareness. To ensure the success of these groups, we have had expert guidance (see acknowledgments). In addition, we have facilitated house staff support meetings[30] and other reflective discussion groups and have observed how increased personal awareness enhances clinical effectiveness and personal satisfaction.

In this article, we draw on these experiences as well as the literature to suggest a curriculum for physician personal awareness, which includes core topics for reflection and discussion. We also describe a variety of organized discussion groups that can promote physician personal awareness. We hope this presentation will be of interest both to educators who seek to integrate personal awareness activities into medical training and to practicing physicians, for whom enhanced personal awareness could benefit their patients and themselves.

A CORE CURRICULUM: TOPICS FOR DISCUSSION AND SELF-EXPLORATION

In this section we present a core curriculum in personal awareness (Table), issues worthwhile for every clinician to explore. (This list has been adapted into a formal residency curriculum, which includes guidelines for individual sessions, readings, and audiovisual resources, available from the first author.) We focus on 4 topic areas related to the practice of medicine: physicians' attitudes and beliefs, their feelings and emotional responses, challenging clinical situations, and self-care. We discuss the significance of a variety of issues within these topic areas and pose ideas or questions that might be considered during personal or group reflection.

Physicians' Beliefs and Attitudes

Core Beliefs/Personal Philosophy.—People have core beliefs and attitudes that are seldom fully articulated and sometimes are organized into a personal philosophy about life.[40] These beliefs and attitudes explain why things happen as they do, define right and wrong, and characterize the nature of one's responsibility toward others. They often contribute to or are defined by one's spiritual beliefs. Other beliefs are about the intrinsic trustworthiness and goodness of others, about how much control one needs, about expectations of good or bad outcomes of one's actions, and about one's inherent self-worth. Core beliefs and attitudes can profoundly affect how physicians listen, interpret, and judge patients' stories and how physicians may empathize with patients and counsel them. Physicians also have beliefs about their roles as physicians. For example, we have pilot data showing that medical residents who see medicine more as a calling than a job experience less psychological distress (D.H.N., T. Bledsoe, MD, W. Rakowsky, MD, unpublished manuscript, 1994). Examining core beliefs about medicine can help answer questions such as, "How available do I need to be to my patients? What are the scope and limits of my responsibilities to patients? Should I treat psychosocial and mental health problems?"

Dysfunctional beliefs may adversely affect patient care. Martin[35] identified 4 common dysfunctional beliefs of physicians: limitations in knowledge is a personal failing; responsibility is to be borne by physicians alone; altruistic devotion to work and denial of self is desirable; it is "professional" to keep one's uncertainties and emotions to oneself.

Certain contexts shape physicians' beliefs and attitudes, which in turn influence patient care. These contexts include one's family of origin, sex, and sociocultural milieu.

Family of Origin Influences.—One's attitudes, feelings, and behaviors are often influenced by patterns in one's family of origin.[15] Certain interaction patterns may be passed from generation to generation. Examples are attitudes and behaviors concerning intimacy, anger, and conflict resolution. One learns first from one's family about the nature, benefits, and pitfalls of caring, about the roles of the caregiver, about the balance of giving and receiving, about the communicative aspects of illness, and about how to respond to distress. These dynamics are fundamentally important to the physician-patient relationship. Patients may remind physicians of family members with similar problems or behavioral patterns. Unrecognized identification of patients with family members can elicit feelings including fears of harming the patient, of inadequacy, of loss of control, and of addressing certain difficult topics.[22] Useful questions to consider are "What roles did I have in my family? How might I be replicating these roles in my work environment? What lessons did I learn from my family about the nature of relationships, about the nature of caregiving, and about acceptable responses to illness? What kinds of patients might I be likely to associate with family members?

A Core Curriculum for Physician Personal Awareness

Physicians' beliefs and attitudes
Core beliefs/personal philosophy
Family of origin influences
Gender issues
Sociocultural influences
Physicians' feelings and emotional responses in patient care
Love, caring, attraction, and boundary setting in medical care
Conflict/anger
Challenging clinical situations
"Difficult patients"
Caring for dying patients
Medical mistakes
Physician self-care
Balancing personal and professional lives
Preventing and managing stress/burnout/impairment

Gender Issues.—Sex is a core element of identity, and sex-role attitudes and expectations affect communication. Sex thus affects professional development, clinical decisions, and the physician-patient relationship.[41] Women are underrepresented in certain specialties such as surgery[42] and are promoted more slowly than men.[43] Women physicians engage in more preventive services[44] and screen patients at a higher rate than men physicians,[45,46] in part because women physicians have stronger beliefs about the importance of screening for mammography and cervical cancer and report more comfort in performing Papanicolaou tests and breast examinations.[47] Female medical students may be more interested in psychosocial aspects of medicine than their male peers.[48]

A variety of other studies illustrate how attitudes related to sex affect care: In 1 study, physicians read brief case histories said to describe a man (or woman) with low back pain or epigastric pain. Although these conditions affect both sexes equally in the general population, "female" patients were said to be overdemanding of clinicians' attention, more likely to present with psychosomatic illnesses, and more likely to have conditions in which emotional factors are prominent.[49] In another study, women physicians conducted longer medical

visits, talked more, and used communication strategies that were more patient-centered and more positive.[50] Male physicians, in another report, frequently responded to women's questions with an answer that was less technical than the question, which may have been partially responsible for those women patients' tendency to ask more questions and to question their doctors' explanations.[51]

Differing aspects of psychological development of men and women affect core attitudes, expectations, and communication styles.[52] Thus it can be useful for men and women students and physicians to discuss their sex-related attitudes as they affect their communication with patients and each other. Useful questions include, "What messages did I receive from my family and society about sex roles? How have my attitudes contributed to instances of miscommunication with others of the opposite sex? Are there any differences in the way I respond to male and female patients? In the way male and female patients respond to me? Do I respond differently to feedback from male or female colleagues?"

Sociocultural Influences.—A variety of sociocultural influences shape physician attitudes that affect patient care. For example, physician transmission of information to patients is related to characteristics of patients (sex, education, and social class) and physicians (social class background and income).[53] Sociocultural norms influence physicians' attitudes toward acceptable illness behaviors, obesity, sexual behaviors, geriatric patients, "family values," the importance of work, and many other emotionally charged issues. Moreover, some contend that medical training constitutes a distinct culture that facilitates socialization into the profession.[54-56]

Sociocultural influences may especially shape physician behaviors when interacting with patients and professionals from different cultures. In addition, a substantial number (more than 40% in internal medicine residency training programs) of physicians in training are foreign born and trained. These residents face a number of challenges, including prejudice,[57] language problems, and differences in cultural norms. For instance, Pakistani and Indian residents often come to the United States without formal training in pelvic examinations (for male residents) or testicular examinations (for female residents), because in their cultures it would be inappropriate for patients to seek care related to sexual health from physicians of the opposite sex. It is therefore important in educational settings to encourage discussion of similarities and differences in cultural norms and assumptions and to provide a safe, secure atmosphere in which to explore cross-cultural awareness.[58]

In exploring sociocultural influences on attitudes, it can be useful to ponder and discuss these questions: "To what culture do I belong and/or with what culture do I identify? What values come to mind that I particularly like and dislike as I reminisce about my cultural heritage? In reflecting on a cross-cultural interaction with a patient or colleague, what factors helped me feel a sense of congruence ('in synch') and/or a sense of dissonance ('out of synch'). How has the 'culture' of medical training affected my attitudes? What is my institutional or practice culture and how does it respond to my needs?"

Physicians' Feelings and Emotional Responses in Patient Care

While medical care evokes a wide variety of feelings in physicians that affect their interactions with patients, we focus on 2 core emotions: love and anger.

Love, Caring, Attraction, and Boundary Setting in Medical Care.—Physicians' love and caring for patients contribute to patients' experience of physician empathy and can be healing.[1,59] However, this love and caring are only beneficial if framed within clear, mutually understood boundaries.[60] Sometimes, perhaps because of unmet personal needs, physicians may send unintended messages or become too emotionally invested in certain patients. For physicians in small towns, whose neighbors and friends become patients, and for physicians whose family members fall ill, setting clear boundaries may be especially difficult.[61,62] Also, patients may misinterpret appropriate caring and empathy. Because physician-patient relationships often engender a special intimacy, there is potential for powerful feelings of attraction to be aroused in both caregiver and patient.[63] These feelings may induce physicians to become overly distant, engendering patient and physician dissatisfaction, or to become overly involved emotionally or even sexually, which will have serious psychological and clinical consequences. Personal awareness and understanding of emotional reactions to patients allows physicians to appropriately set effective boundaries that allow for both objectivity and connectedness with patients.[16,64]

Anger/Conflict.—Some fear anger as potentially destructive, some see anger as natural and sometimes helpful in relationships, and others may welcome and invite conflicts as a way of defining themselves and relating to others. Physicians who have predominant fears of or attraction to anger and conflict may find that these attitudes affect their patient care. Physicians vary in the kinds of situations that will arouse their anger, and their abilities to tackle certain issues may be affected by personal associations. They have varying skills in conflict resolution, which in turn affect their attitudes toward conflict. Self-knowledge about the sources and triggers of one's anger and attitudes and skills related to conflict are particularly important because anger is a common response to illness, suffering, and death. Physicians also must work with diverse members of a health care team, including managed care administrators, whose outlook and behavior may not match the physician's expectations. Useful questions include the following: "What sorts of patients elicit an angry reaction in me? What work situations usually make me angry and why? What are my usual responses to my own anger and the anger of others (eg, do I overreact, placate, blame others, suppress my feelings, become superreasonable?)? What are the underlying feelings when I become angry (eg, feeling rejected, humiliated, unworthy)? Where did I learn my responses to anger?" Discussing this topic with others and trying out alternative strategies for dealing with anger[65-68] can enrich and deepen one's understanding.

Challenging Clinical Situations

Certain common challenges in clinical practice best illustrate the importance of understanding one's attitudes and emotional responses to patients.

Difficult Patients.—All physicians find some patients "difficult," some even "hateful."[69,70] Many of these patients have symptoms that elude understanding and fail to improve with appropriate therapy, despite high-quality efforts to diagnose and treat disease. Many have major psychosocial stresses in their lives and psychiatric diagnoses[71,72] that determine the nature of their symptoms and responses to treatment. These patients have more functional impairment, health care utilization, and dissatisfaction with care.[72] Physicians' attitudes about working with patients who have psychosocial and behavioral problems can determine their clinical effectiveness with these patients. Moreover, a physician's emotional reactions to a "difficult" patient can provide important clues to the patient's emotional state.

While most physicians may find certain patients "difficult," some physicians, because of personal biases, may find some patients particularly difficult (eg, alcoholics, obese people, dependent patients, hypochondriacs). These biases may prevent some physicians from acquiring the skills to effectively treat these patients. By discussing their thoughts and feelings about

specific patients, physicians can help each other understand their personal biases, relieve some of the emotional pain that may be associated with these biases, and help each other gain new perspectives in working with various kinds of "difficult" patients.

Caring for Dying Patients.—Shortcomings in physicians' communications with dying patients lead to needless suffering.[73] Few training programs offer sufficient attention to communicating with dying patients,[74,75] even though such training can improve student attitudes.[76] Experiences with death and fears of vulnerability and death profoundly influence physicians' care of chronically ill and dying patients,[63] the giving of bad news to patients and families,[77] discussion of advance directives,[78,79] and work with grieving patients and families.[80] Because of their attitudes and beliefs about death or the emotional pain of losing a patient, physicians may become distant or overinvolved or may undertreat or overtreat the terminally ill. Reading literature and poetry about the experience of dying[81] and physician accounts of their own terminal illnesses[82-85] can aid personal reflection. It can be useful to discuss with other physicians personal attitudes and experiences of communicating with grievously ill patients and their families and to focus on such questions as the following: "How have my personal experiences with loss and grief affected, enhanced, or limited my abilities to work with dying patients? What are my own attitudes and fears of death and vulnerability, and how do they affect my patient care? If I were dying, what would I want and need from my physician?"

Medical Mistakes.—Physicians' attitudes, beliefs, and responses to mistakes can greatly influence patient care.[86,87] Though they cognitively understand that it is human to err, many physicians may nevertheless feel that they ought to be perfect. These physicians will experience excessive guilt and shame if they make mistakes, especially mistakes that lead to adverse outcomes. Physicians may be troubled for years after a mistake, may order excessive diagnostic testing to avoid mistakes, and may inappropriately treat patients based on overgeneralizing from a mistake.[88] Physicians who do not accept the limitations of their responsibility for all that happens to patients and the limitations of their craft may define adverse outcomes as mistakes (even when most other physicians would have made similar treatment decisions). Many physicians will not discuss their mistakes with others, making it less likely that they will learn from their mistakes or heal emotionally. Many who feel that they made serious mistakes will withhold information or offer misleading information to families,[89,90] which may increase their sense of guilt and shame. Those who accept responsibility for a mistake and discuss it may be more likely to make constructive changes in their practices than those who attribute mistakes to job overload.[89] Patients want physicians to disclose mistakes, and patients say they are less likely to litigate after disclosure than if they discover physician's errors by other means.[91] It may be especially beneficial for physicians to discuss their mistakes with other physicians, organizing their discussion into 5 topic areas: "What was the nature of my mistake? What are my beliefs about the mistake? What emotions did I experience in the aftermath of the mistake? How did I cope with the mistake? What changes did I make in my practice as a result of the mistake?"[92,93] Participants in such discussions can formulate effective approaches for preventing and responding to mistakes, both at the systemic and personal levels. These discussions also promote a collaborative model of training and practice in which physicians' support for each other promotes a climate for discussing and learning from mistakes.

Physician Self-care

Physicians cannot be completely effective in patient care if they are distracted by distressing personal issues. Reflection and increased self-awareness can help maintain a more satisfying balance between personal and professional activities. Physicians can also monitor their stress levels and formulate adaptive responses to stress as a way of preventing "burnout."

Balancing Personal and Professional Lives.—Physicians often complain of having "unbalanced" lives, with too much time devoted to work. Overdedication to work can lead to professional dissatisfaction, unhappiness at home, physical and emotional problems, and resentment and impatience with normal patient care demands. Conflict at home may exacerbate this imbalance as physicians further retreat into work. The myriad responsibilities of patient care may appear to leave physicians with little control over their time. However, physicians invariably make choices and may leave certain assumptions unchallenged. Bringing these choices and assumptions to light can help physicians relinquish a stance of "victim" and take more responsibility for their choices and their lives. They can also choose to set aside time to work on improving relationships with significant others, setting goals, reading, trying new behaviors, and attending courses that promote improved relationships.[68,94] Useful questions to consider include, "What would be an ideal distribution of time between work, play, family, and personal growth and development? What are the barriers to achieving balance in my life? In what ways could my assumptions and beliefs be a barrier to change? In what ways is the current imbalance benefiting me and would I be willing to give that up?"

Preventing and Managing Stress/Burnout/Impairment.—Imbalance in life contributes to physician stress. There are many other stressors, including work overload, administrative and financial pressures, and dealing with patients' suffering. Some studies find that about 25% of physicians experience psychiatric morbidity and burnout.[95-98] Burnout often means impairment, including depression and alcohol and other drug abuse in training programs as well as in practice.[36,38,99] Physicians for whom patient care satisfies unmet emotional needs, because of past deprivations or current personal difficulties, may be especially prone to drug use, marital instability, and mental health problems.[38] Awareness of personal factors that contribute to stress and coping can lead to adaptive behavioral changes. Enhanced personal awareness could counteract the denial of feelings that promotes maladaptive responses to stress. Time set aside for reflection and discussion facilitates identification of internal and external stressors in training and practice, effective strategies for managing stress, changes that can be made in attitudes and behaviors, and ways of understanding and improving relationships. It is useful for colleagues to evaluate and discuss their successes and failures in attending to their priorities and to develop strategies for rearranging priorities to keep them consistent with personal and professional goals.[28,100,101]

Using Group Discussion to Promote Physician Personal Awareness

A variety of group discussion activities in medical training or organized for practicing physicians can promote personal awareness. Depending on the depth of exploration desired, some activities require experienced facilitators to create a supportive atmosphere that ensures safety and confidentiality while encouraging participants to focus on the relevant topics and emotional issues. These activities are generally not meant to be psychotherapeutic in the sense of focusing on self-awareness to treat the emotional distress of individual participants. Facilitators usually articulate

clear limits to the scope and range of the discussion and inquiry, urging participants to share as much or as little as their comfort allows. For the most part, group discussions focus on personal awareness as related to clinical care and professional relationships to enhance participants' effectiveness as clinicians and colleagues. In the process, however, participants may gain useful insights helpful to their personal lives as well. Key issues listed above can be formally or informally discussed in many of these activities.

Support Groups.—Some medical training programs organize regularly scheduled group sessions to help trainees establish a balance between the human and technical aspects of clinical care.[102-105] Practicing physicians sometimes organize support groups in their communities.[106] Although they vary in their content and structure, support groups provide opportunities for working through the broad range of conflicts that inevitably arise in clinical care and medical training.[39,107] At the Rhode Island Hospital, a weekly meeting was attended by between 5 and 30 house staff, depending on need.[39] For example, when a resident developed a malignancy, virtually the entire house staff attended. Pressing emotional issues were often discussed. "One of my patients asked me to turn off his respirator this morning. What should I do?" or "The pulmonary fellow accused me of murdering his patient! Did I call off the code too soon?" House staff often faced their fears and inadequacies and learned from their colleagues. Support groups can also be used in an ad hoc fashion. One of us (C.K.) suggested an impromptu house staff meeting when a resident's 4-year-old child died suddenly. House staff and faculty attended the 2-hour session to reflect on and discuss the strong feelings that arose from this incident.

Balint Groups.—In the 1950s, Michael and Enid Balint suggested that the most frequently used "drug" in medical practice was the physician and proposed studying the properties of this therapeutic agent.[24] They met regularly with a group of general practitioners, who took turns describing their interactions with challenging patients and families. Group members worked to understand their attitudes and motivations in their interventions with patients. With the help of the Balints and their colleagues, enhanced personal awareness often led to enhanced clinical effectiveness. Since then, Balint groups[108] have become an important curricular component of many family medicine residencies[109,110] and occasional continuing medical education programs.[111] Many current Balint groups use formats distinct from the psychoanalytic focus of the original group formats. Facilitators represent a broad range of disciplines, including psychiatry, psychology, family therapy, and family medicine, each of which has made contributions and refinements to the format.[111] In addition to discussing challenging patients, sessions may also focus on other issues such as balancing personal and work lives, relationships with colleagues, and ethical dilemmas. The International Balint Federation[112] promotes these activities.

Family of Origin Group Discussions.—Family of origin group discussions are a curricular component of many family medicine residency programs to help trainees better understand their strengths and blind spots when counseling families. In these exercises, participants construct personal genograms and discuss them in facilitated small group settings. Genograms are family trees that graphically depict the nature of relationships between family members. Conflicts, family roles, strengths, myths, expectations, "triangulation," and other qualities of family dynamics are discussed to the extent that group members feel comfortable. Group members discuss how their families of origin have given them particular strengths and insights. These sessions help participants to place their individual difficulties in a larger family and social context and to reflect on their own characteristic ways of relating. By adopting an explicit focus on strengths rather than shortcomings, participants can learn about themselves in an environment of psychological safety and empowerment.[3,113]

Meaningful Experiences Discussions.—In focused workshops at the national meetings of the Society of General Internal Medicine and in AAPP faculty development courses, participants have shared meaningful experiences in their clinical work.[114,115] Faculty have asked medical students on clinical rotations to write brief narratives about meaningful patients and to reflect on their learning.[116,117] Physicians' and students' stories are often "critical incidents"[118] that were meaningful because of a sense of connection with patients,[119] because they substantially changed their interactions with patients, or changed their perceptions of their caregiving roles.

Personal Awareness Groups.—Personal awareness groups are an integral feature of AAPP faculty development and practitioner courses and are scheduled as daily 2-hour sessions during a 2-day to 5-day course. The "PA" groups are unstructured at the start and evolve according to the needs, concerns, and cohesiveness of the 7 to 12 participants. The guiding principle is to reflect on personal issues that influence group members' effectiveness as clinicians and teachers. With expert facilitation, these sessions generate insights into barriers to successful patient or student interactions and offer a chance to experience the empathy and support of group participants. These groups may decide to use role play or other activities to move beyond the cognitive and actually experience new behaviors in a safe setting.

Literature in Medicine Discussion Groups.—Perhaps one third of medical schools offer literature in medicine courses.[120] Literary works, especially those that describe patients and their physicians and physicians' stories,[121] enhance understanding and empathy for patients' experiences of illness as well as the meanings and conflicts of the physician's calling. Literary discussion helps participants distinguish logico-scientific knowledge from narrative knowledge. While logico-scientific knowledge can be learned from books or lectures, narrative knowledge demands the active participation of the reader (or the physician listening to a patient's story). Active participation consciously uses life experiences, values, memories, and character traits in ascribing meaning. Literary traditions of reading, narrating, and reflecting provide an alternative route to increased personal awareness as discussion group participants examine differing meanings and interpretations that arise from sharing stories.[120,122]

Behavioral Science/Interpersonal Skills Curricula.—Medical school and residency behavioral science curricula may include discussion groups and other experiences that promote personal awareness. Faculty use small group formats to stimulate and discuss students' personal reactions to a variety of topics commonly presented in medical school curricula,[123] such as life cycle issues, sexuality, family relationships, and personality styles. Faculty discuss difficult issues in clinical care, such as exploring patients' sexual problems or working with dying patients, encouraging trainees to share experiences, beliefs, and fears.[124]

In residency interpersonal skills training programs,[21,125,126] faculty review audiotapes and videotapes of trainee-patient interactions or watch trainees interact with patients in "challenging patient" case conferences.[127] Teachers may ask about feelings, cognitions and motivations, and residents' nonverbal behaviors when interacting with patients. Residents can then better understand why they asked about or avoided certain issues and how their reactions to patients might serve as useful diagnos-

tic material about patients and about themselves. Students and residents may participate in self-help groups, such as Alcoholics Anonymous, or in actual or role-played "being a patient" exercises.[123] Subsequent group discussions can increase trainees' understanding of their own feelings and perspectives on vulnerability, control, and body image as related to self-esteem.

Thus, physicians wishing to incorporate activities promoting personal awareness into training or practice have many approaches at their disposal. Although varied in format, each of these activities encourages participants to reflect on their responses to the difficult interpersonal encounters of clinical and teaching settings. Sometimes interactions between participants in group discussions provide material for reflection and discussion. It can be helpful for participants to review chapters from books that encourage self-reflection.[55,68,129-131] Some participants may be encouraged to undertake organized activities in their personal time, such as PAIRS (Practical Application of Intimate Relationships) programs, which focus on enhancing skills that facilitate intimate relationships.[68]

COMMENT

Data on the effectiveness of self-awareness programs are scarce and often anecdotal.[106,132-135] Some have described outcomes of structured approaches. For example, McCue and Sachs[136] describe a stress management workshop for residents with the goals of (1) learning and practicing interpersonal skills that increase the availability of social support; (2) prioritization of personal, work, and educational demands; (3) techniques to increase stamina and attend to self-care needs; (4) recognition and avoidance of maladaptive responses; and (5) positive outlook skills. Residents in the intervention group had significant improvement in measures of physician stress over a control group. Mushin and colleagues[137] have instituted a residency curriculum in professional development that encourages self-reflection, with excellent evaluations by participants. Clearly, far more research is needed into the effects of personal awareness activities on physicians and their patients. Nevertheless, until better data exist, and because physician personal awareness is so important to the practice of medicine, it seems sensible to include as a regular part of medical training activities that allow for reflection and discussion of personal aspects of clinical care. These activities could be integrated into existing interpersonal skills and behavioral science courses[20,124,138] as well as into clinical rotations. Because personal awareness and growth are lifelong processes, it could be useful for practicing physicians to engage in personal reflection and participate in Balint groups, support groups, or other organized activities that promote personal awareness.

The process of enhancing personal awareness can also enhance physician psychological well-being. Many lines of philosophical and scientific inquiry suggest that "wellness," or positive psychological functioning, consists of the processes of setting and pursuing goals, attempting to realize one's potential, experiencing deep connections with others, managing surrounding demands and opportunities, exercising self-direction, and possessing positive self-regard.[139] Trainees and practicing physicians who pursue activities that enhance personal awareness in medical practice may also work on improving these aspects of their personal lives. Enhanced physician well-being should have benefits for patients as well.

Physicians may not fully learn how their values, attitudes, expectations, and biases affect their caregiving unless they have a chance to explore these issues in protected settings.[140] Too often, physicians learn difficult lessons in solitary reflection or by chance discussions in hallways or cafeterias. More unfortunately, they can also learn difficult lessons through professional censure or malpractice litigation. If medical educators respond to the challenge of instituting and evaluating activities that promote personal awareness, it could have important consequences for physicians and patients. Enhanced personal awareness should help trainees and practicing physicians become more effective in their care of patients and should increase professional satisfaction, perhaps preventing or alleviating burnout.[16] Those who are more satisfied with their practices have more satisfied patients.[141] Physicians who understand their attitudes toward work and toward their profession can make reasonable choices about structuring their work. Those who understand their needs and abilities in relation to others can function more effectively as members of health care teams and as members of families. Including personal awareness as part of medical training may help to establish a different training culture—one that is cooperative rather than competitive. Instead of producing "iron men" and "iron women," a curriculum in personal awareness could help engender cooperation, respect, and trust among health professionals. By focusing on enhancing personal awareness in training and in practice, its importance will become widely appreciated as a key to the effective use of clinical skills and as a basis for medicine's healing art.

Other members of the Working Group on Promoting Physician Personal Awareness who contributed significantly to this article: Mary O'Brien, PhD, Allegheny University of the Health Sciences, Philadelphia, Pa; Rosaleen Gregg, MBBS, Saint Bartholomew's and the Royal London School of Medicine and Dentistry, London, United Kingdom; Stuart Green, MSW, MA, Overlook Hospital, Summit, NJ; and Richard Frankel, PhD, Primary Care Institute, Rochester, NY.

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