Special Article

Working With the Resident in Difficulty

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ABSTRACT

The resident in difficulty is an omnipresent and seemingly intractable problem. Some definitions of this concept are explored, as are means and methods of problem identification. Principles of successful intervention are discussed, as well as some obstacles to successful intervention. Utilization of interpersonal process recall, behavioral techniques, and a more insight-oriented approach in the remediation process are emphasized. The role of the faculty in responding to the resident in difficulty is explored, with special consideration to pitfalls and possibilities. The article concludes with a series of questions and directions for future exploration.

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Physician impairment and impairment among physicians in training is a major issue of the medical profession.[1,2] Drug and alcohol abuse are common problems among this population, as are depression, suicide, unhappy marriages, and stifled personal lives.[3,4] Recent research suggests that emotional impairment among physicians in training, particularly residents, is on the increase.[5] It is likely that the impaired resident is the antecedent of the impaired physician. However, it is also likely that sometimes the antecedent of the impaired resident is a vaguer, less identifiable, but perhaps equally problematic category. We have chosen to label this condition "the resident in difficulty" because it connotes a less critical, less pejorative, less pathological, and (one hopes) more easily remediable condition than full-scale impairment.

For every seriously impaired resident, struggling with major cognitive deficits, significant psychiatric disorder, or substance abuse, there are many more "unhappy and maladapted"[6] residents troubled and dissatisfied in their work and in their personal lives. These residents have been labeled as suffering from social impairment[7]—competent individuals who perform adequately academically but who do not make good doctors because they lack the ability to empathize and form alliances with patients and colleagues.

Many of these residents tend to be perfectionistic, to hold unrealistically high expectations for themselves.[8] The consequent pervasive sense of inadequacy may lead to denial or rationalization of medical mistakes. Defensive strategies, such as denial, discounting, and distancing, are commonly adopted.[9] There may be evidence of emotional withdrawal or lability and isolation, stereotyped or disorganized thought, anger, avoidance, hyperactive behavior, anxiety, unreasonable contentiousness, uneven performance, depression.[10,11] Often such residents are workaholics who neglect their personal needs and repress or intellectualize their emotions.[12] More subtle, but perhaps at least as serious, one may observe a certain "hardening of the spirit"[5] in these residents—the only survival mechanism they know for coping with the stress and demands surrounding them.

Common Faculty Responses

Acknowledging that residents in difficulty do exist is difficult enough. The next step, appropriate faculty and departmental response to such residents, is even less clear, often idiosyncratic and haphazard, sometimes filled with anguish for both resident and faculty member.

Despite the relative paucity of well-defined faculty roles in this area, most residencies have at one time or another attempted some sort of remediation outreach for residents in difficulty. However, whereas faculty perceive themselves as sufficiently supportive of residents in difficulty, a widespread perception among residents is that faculty are insufficiently supportive.[13] Among other things, this finding is suggestive of a certain ineffectualness in current efforts at remediation. Thus, it is important to examine some of the potentially ineffectual responses that might lead to this conclusion.

At times, some faculty will collude with the resident by denying that a problem exists at all. Denial on the part of the faculty is one of the primary reasons why early intervention, so often indicated, so rarely occurs. Superficial excuses—being too busy, concern that the resident has not been fairly and fully assessed, hopes that the

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resident's difficulties are transitory and will resolve on their own — are common. One likely difficulty in successfully introducing an intervention comes from the dilemma of asking physicians who themselves have perhaps suffered from lifelong neglect of their own emotional needs to identify and minister to such needs in their younger counterparts.[14] Also, up to a point, the very qualities which may get a resident into difficulty are those which the faculty prizes. The "heroic" resident, though definitely more myth than reality, initially makes life easier for faculty. Faculty who deny limits or vulnerabilities in themselves may be extremely reluctant to acknowledge their existence in another.

In contrast to avoidance and denial, certain faculty occasionally may be afflicted with a kind of messianic complex. When these faculty encounter a resident in difficulty, they experience a strong desire to rescue or salvage this particular individual. As well-meaning as the tendency might be, the good Samaritan impulse had better be more than glib rhetoric; otherwise, it may result in a flurry of good intentions without an appropriate plan or follow-through. Also, it is not uncommon that faculty apparently desperate to "save" a resident are in reality struggling to save themselves from similar problems and are therefore significantly at risk for being sucked into the vortex of the resident's own difficulties. While it cannot be explored further here, the interaction of physician-resident impairments, like the interaction of physician-patient impairments, is a fruitful one for examination.

In addition to avoidance and rescuing, another common faculty response to the resident in difficulty is anger. Sadly, there is a tendency not to see the individual as a resident in difficulty but as a difficult resident, or worse, simply as a difficulty. At times, faculty feeling toward such residents mirrors physician feeling toward the "difficult patient."[15] There is a similarity in the strong negative reaction elicited and in the sense of helplessness to control or change the situation. These residents may even cross the line from the "difficult" resident to the "hateful" resident[16] because of the feelings of frustration and impotence engendered in the faculty. Frequently such residents fall into a teaching limbo in which they are unconsciously punished by faculty or confronted with self-righteous anger. As with the problem patient, there may exist in faculty an impulse to "dump" these residents. Their graduation or leave-taking is accompanied by a sigh of relief, but the problem has usually not been resolved.

It is frequently found, both anecdotally and in the literature, that many suggestions for intervention tend to focus primarily on professional counseling and/or participation by the resident in an organized support group.[17,18] (For a different approach, see the UCLA program.)[19] Of course, both counseling and participatory groups are excellent supportive measures to help residents in difficulty. However, outside counseling alone, unless carefully arranged, at times may be less than optimal because the therapist has an insufficient understanding of the complexities of surviving and functioning in the medical system, and simultaneously may be dealing with countertransference issues regarding physicians. Support groups, similarly, are an excellent tool for any residency program; but for the more vulnerable resident, they may be perceived as too revealing and too dangerous. Often it is precisely the resident who needs help the most who participates in such groups the least.

It is our conviction that in most cases of residents in difficulty, a clearly specified role for faculty in intervention is essential. This will not only benefit the resident but the faculty as well, since they are often disheartened and demoralized by the presence of a resident everyone pretends is not there. What follows, then, is a discussion of a more constructive approach for faculty on two levels — the systemic and the personal.

Developing a Framework

One of the most useful and hopeful faculty and departmental responses to the problem of residents in difficulty has been in the area of primary prevention.[17,20] The philosophy of prevention is harmonious with respectable and popular tenets in family medicine today and wisely recognizes that it is easier and less costly to anticipate than to rehabilitate. In many programs, including our own, positive efforts have been made to introduce meticulous screening procedures for resident applicants. These include mandatory interviews by behavioral science faculty and a careful perusal of the applicant's file for potential red flags. There have also been commendable attempts to address problems of impairment during the student years.[21]

The seduction of such primary prevention is that it may encourage a belief that hypervigilance in selection will obviate the consequences of dysfunction further on in training. Unfortunately, it is impossible to completely weed out the resident in difficulty. The state of being in significant difficulty (presumably not unknown to many readers) is very likely a part of the human condition and therefore inescapable.

It is critical that the subject of impairment not be taboo within the residency. Thus, faculty must be comfortable with the idea that physicians, like other people, are imperfect and can have problems, sometimes very serious problems. They must also be comfortable modeling such insights before residents. An ideal opportunity to introduce this concept is during an orientation week,[22] which is also the optimal time to present workshops and discussions on stress management, coping skills, interpersonal communication, and community resources. It is important to include spouses and significant others in these experiences, as they are often the group first affected by the resident's dysfunction. However, it is equally important that such efforts at secondary prevention, while indispensable, should not be restricted to an orientation week. Rather, such themes should become integral

parts of ongoing noon conferences, resident meetings, and sessions with faculty advisors.

Faculty need to be aware of, familiar with, and supportive of departmental procedures for identifying a resident in difficulty. Faculty need to be aware of specific criteria for identifying the resident in difficulty and of what steps they should follow in terms of bringing this resident to the attention of the department. Unless residents can be helped to realize that an organized, systematic departmental program exists for dealing with residents in difficulty, they are likely to feel abandoned on the one hand or persecuted on the other. Individual faculty, by their own involvement or lack of it, can significantly reduce or enhance these responses.

It is extremely helpful to develop specific behavioral criteria for identification of a resident in difficulty. Such criteria lend a certain rigor and objectivity to what is inevitably a painful process, fraught with risk for both resident and faculty. Some objective criteria suggesting a resident in difficulty might include unkempt or bizarre attire, consistent late arrival and/or early departure from clinics and rotations, or repetitive "accidents" or personal emergencies which require the resident to be absent from patient care situations.

Another fruitful area for objective assessment of potential difficulty in a resident is in the evaluation of doctor-patient interactions in the clinic setting. Many models exist for defining and identifying interviewing and interaction skills.[23-25] In our own program, we have devised an assessment instrument based on criteria reported in the literature[26] which is applied to every resident on a quarterly basis to provide systematic feedback about basic interviewing techniques. In general, residents in difficulty, as identified by other measures, tend to exhibit poor performance in interactive and empathetic skills. It is important not to look at such information in isolation, however, as performance among residents as a group in these areas tends not to be strong[27]

In a similar vein, it is critical to be as specific as possible in determining the nature of the resident's difficulty (see Appendix I for examples of categories developed in our own program). Obviously, there may be considerable imprecision in developing such a categorical approach, but it does serve to help faculty agree on a focus for intervention. This focus may change as the intervention process progresses, but it gives everyone, including the resident, a starting point.

Ideally, in making a determination of the resident in difficulty, it is useful to solicit feedback both from patients seen by the resident and from the resident him or herself. At the same time, responsibility for identification of difficulties lies ultimately with the program. While either implicit or explicit cries for help from residents should never be ignored, denial of difficulty on the part of the resident should not in and of itself be the last word on the subject.

A note of caution is in order here. The above suggestions are suggestions *only* for identification and assessment of the resident in difficulty. While multiple measures of assessment decrease the likelihood of spurious or trivial allegations, few programs are set up to execute such a thorough assessment each time concern is registered about a resident. The point is to simply make the best, most comprehensive effort possible, given the resources of the department, and above all not to ignore the resident in difficulty because of shortcomings in the system of detection.

Intervention, at best, is a confusing and difficult issue involving delicate boundary considerations. For both ethical and training reasons, it is inappropriate for a faculty member to develop a sustained and deeply intimate personal or counseling relationship with a resident. At the same time, it is often only by entering into a caring and involving relationship with a resident that problematic behaviors can be addressed. Thus, the faculty member must not function independently of the rest of the faculty, but should be part of a well-orchestrated plan of intervention.

It is equally important from the standpoint of faculty unity that one specific individual or subset of the faculty not be identified as the "hit team." (This is especially true for the behavioral science faculty which is often perceived as responsible for "blowing the whistle" on a resident.) Faculty playing key roles in any intervention process should be determined by several factors: (1) their degree of involvement with the resident in question; (2) their degree of expertise and comfort with the problem involved; (3) their availability. Thus, in our program, faculty involved in intervention attempts usually include the residency director and/or the associate residency director, a representative from the behavioral science faculty (not always the same individual), the resident's personal advisor (generally in an advocacy role), sometimes the resident's academic advisor, and a faculty member from the family practice clinic who has worked closely with the resident. This unified approach communicates that the faculty is at least in partial control of the situation, has a plan of action and a set of guidelines, and is motivated by a desire to rehabilitate the resident. While not all faculty should be involved in every intervention, all faculty have the right to know clearly the specific concerns regarding a particular resident, the specific conditions of the remediation plan, and identifiable goals and objectives for successfully completing the plan.

In addition to determining who should be involved, it must also be decided when to intervene. Intervention with the problem resident is more likely to succeed during early residency, preferably in the first year. The reasons for this are straightforward. First, the time available for remedial work is greater, partly because of the lighter patient load in clinic, partly because of the greater length of time remaining in the program. Secondly, the resident's style as a physician is not so completely formed during the internship. Finally, the resident's expectations in the first year are geared for feedback and guidance, whereas later in training residents adopt

more colleaguial or consultative modes of interaction with faculty.

An additional important structural principle is that the less radical the intervention, the more chance for success it has. The less the resident's normal schedule is disrupted, the less he or she is distinguished and differentiated from peers and the less likely he or she will see the remediation as a punishment. Thus, increased observation of the resident during regular clinic hours, a less strenuous schedule to allow time for feedback and discussion, and an opportunity for modeling more appropriate patient/staff interactions through direct faculty presence are preferable to pulling the resident from an assigned rotation for special intervention.

The faculty must be familiar with several component options for intervention, and be able to mix and match these as required by the resident in question. Such options include, but are not limited to, the following: regular and frequent meetings with a faculty advisor, or other concerned faculty member, to focus on a better understanding of the problem and its eventual remediation; specific skill-training, i.e. assertiveness training, interviewing skills, interpersonal interaction, with either a behavioral science or physician faculty member; sessions with a supervising faculty member for the resident to work on family of origin issues; referral for outside counseling or psychotherapy; participation in an in-house support group; participation in community support groups; and monitoring and assessment of problematic behaviors. Ideally, during the course of intervention, other individuals who have a significant involvement with the problem should be included on an occasional basis. This list might encompass spouse or family members, faculty, staff, or other residents, depending on the nature of the referral problem.

Thus, faculty must work to construct a system which is both humane and objective: which does not penalize the resident in distress, but reaches out a lifeline to this individual. In order to accomplish this successfully, however, faculty must first undertake another more difficult task. Simultaneous with creating a comprehensive systematic superstructure for responding to the resident in difficulty, we must also be willing to examine the microlevel of ourselves, to develop better awareness of how our own fears and vulnerabilities may hamper our efforts to extend ourselves therapeutically toward these residents. This is a more subjective and relative process which involves confrontation with our own frustrations regarding interactions with patients, our own level of comfort with emotional expression, our own degree of satisfaction and confidence in our careers, and so forth. We must begin to reconcile and resolve many of the personal issues which lead us into the traps of denial, avoidance, and anger discussed earlier. Until such personal healing has at least begun, it is unlikely that any systemic approach, no matter how carefully orchestrated, will be more than an attractive piece of paper.

Groundwork for Intervention

Once a satisfactory remediation system has been created and faculty are personally comfortable interacting with residents at this level, work with the resident can begin. It is ideal to involve the resident in remediation in a collaborative, participatory fashion. As it happens, residents will occasionally respond receptively and with relief to faculty suggestion that intervention is required. It is more common, however, to find that many barriers exist within the resident to intervention, regardless of the adequacy of the intervention program or the goodwill of the faculty. These barriers, which have been enumerated, include feared loss of status, decreased self-esteem, the fear of appearing to be in need, and the adopting of a dependent (i.e., patient, therefore, feared) role.[11]

The resident identified as in need of psychosocial remediation must go through a cycle of grief and mourning not unlike that described in the death and dying literature.[28] Mourning is necessary because a loss has occurred: i.e., the loss of the idealized (professional) self. Residents involved in remediation may experience reactions of shock and denial, anger, bargaining, depression, and (if the intervention is successful), some degree of acceptance. Thus the faculty identified as intervenors must be prepared to help the resident grieve.

As in all therapeutic encounters, one of the most significant obstacles to successful intervention with a resident is the resident's own resistance and denial.[29] Admitting that while they may be able to handle the problems of their patients they can no longer handle their own, is an unnerving and sometimes demoralizing experience for physicians trained to value skills of mastery, control, curing, and problem solving.[30] Typically, by the time one has reached the level of resident, one has developed a long history of dealing with personal deficiencies and dilemmas by avoiding them, by pretending they don't exist, or by blaming others in the environment as a cause of the problems. Breaking through denial requires a combination of support and confrontation, holding up a mirror honestly yet non-judgmentally to the resident till he or she is willing to take a look.

A corollary of dealing with denial effectively is providing a safe atmosphere for the resident. Denial is often based on a profound fear of the external and internal consequences of accepting the judgment of others. Thus, it is important to create an environment which is as psychologically safe for the resident as possible. This does not mean pretending that there will be no risks during the process of intervention. It does mean that the resident feels valued and respected by the faculty no matter what the outcome or the nature of personal material disclosed.

Approaches to denial vary, depending on the resident's degree of entrenchment. If time is not of the essence, self-observation (through the use of audio and videotapes) may be an ideal way to help a resident develop awareness of a particular problem.

This type of approach, in which the resident provides much of his or her own feedback, often eliminates the defensive rationalizations which can be so unproductive.[31]

At times, however, the resident may turn a deaf ear and blind eye to the feedback of others and explain away or fail to recognize behavioral evidence with which he or she is confronted. In such a situation, it may be worthwhile to consider the type of group intervention popularized in the treatment of alcoholism,[32] where denial also tends to be extremely intransigent. In this case, the resident should be simultaneously confronted by a group of significant concerned others who challenge his or her perceptions of reality and set limits on behavior.

Unfortunately, admission that a problem exists is only half the battle. A recent study by Girard, et al.,[33] reported that first-year residents suffering from depression, fatigue, and professional disillusionment felt that what they needed was to get away, have lighter schedules, and longer vacations. In other words, in order to seek relief from distress, they basically chose strategies of avoidance, not coping. Most perceived counseling and other coping strategies for dealing with their problems as not very useful. This finding is consistent with other studies which have documented the generally negative attitude of physicians toward any kind of psychotherapy.[34] Therefore, it is also important to alter the resident's perception regarding the possible effectiveness of an intervention program. One compelling way of accomplishing this goal is the use of the testimonial, i.e., exposing the identified problem resident to a more senior resident who has previously undergone intervention and benefited from the process.

Finally, residents may express a fear of being changed during the process of intervention. Interns in particular may be experiencing so much external change that the suggestion of internal change appears overwhelming. In this regard, it can be helpful to encourage the attitude that an intervention program will simply add new skills to their existing repertoire; that rather than changing, they will be exploring the limits of their potential as physicians. Very often residents who claim they don't want to be changed are, in fact, afraid that they cannot change at all. Reassurance that personal growth is possible may be a first step toward the resident accepting new strategies and new ways of functioning as a physician.

Behavioral Intervention and Beyond

Actual intervention itself can be approached on two levels. In our program, in which resident-patient interaction problems form the bulk of referrals for remediation, we use the Interpersonal Process Recall approach developed by Kagan and his colleagues.[31] A summary of the methods and goals of this technique can be found in Appendix 2. Regardless of what technique is used, some broad-based considerations are in order.

On one hand, remediation can take an essentially skill-based, behavioral approach. For example, observation may indicate that a resident "has poor eye contact, rarely addresses patients by name, asks no personal questions." For each of these deficiencies, a behavioral objective can be established, successive approximations of the desired behaviors identified, and a detailed structure of behavioral rehearsals paired with appropriate social reinforcers developed. This type of approach is well founded in behavioral literature[35] and often meets with a considerable degree of success. In part, empathy is a skill which can be taught, and often the shy or anxious resident finds inherent rewards in learning how to communicate more fully with patients.

A complementary strategy also exists. Many physician and nonphysician faculty have had the experience of teaching interaction skills to a resident who is able to parrot successfully what is required; but something is missing. Skill-training may degenerate into a mechanistic, technique-oriented model of little value to faculty or resident.[36] This may be because a truly therapeutic encounter with another person (whether patient or resident) involves not only behavioral skills and deficits but also something else infinitely more profound and vulnerable.

A true therapeutic encounter may involve, in addition to criteria such as eye contact, open-ended questions, and dutiful paraphrasing, the capacity to exist as a "wounded healer" in that setting, to allow oneself to be profoundly moved by the patient's suffering. Katz writes of the "intimate, anxiety-producing, and fateful encounters"[37] between doctor and patient. It may be useful for a faculty intervenor to ask, What is it that makes a resident avoid looking at a patient, or laugh nervously when a patient discloses a fear of death? Ben-Sira reports that primary care physicians tend to interpret demonstration of affective behaviors in the treatment setting as a possible threat to their dominance over the patient.[38] If this is the case in a given situation, then it is this underlying fear of loss of control which needs to be addressed.

A compassionate, insight-oriented probing of the resident will at times reveal significant organizing psychological principles which need to be explored. For example, a resident who maintains a distant relationship with his patients is convinced that he is an inferior physician; a resident is so afraid of losing control that he permits himself no displays of emotion; another resident is still unresolved about her own mother's death and unconsciously treats dying patients with apparently callous levity. Facing these hidden, "bad" parts of oneself with compassion and courage is a process of integration which can rarely be completely accomplished within the confines of an intervention program. Generally it takes an entire lifetime to accomplish such a task. However, first steps in this process can be taken.

On occasion, the experience of honestly facing oneself in the presence of another who does not judge or ridicule promotes a certain kind of healing in the resident and gives permission for taking

certain risks, pushing one's professional capacities. Katz again writes that the estrangement of doctor and patient often reflects an inner estrangement of the physician from parts of himself or herself which he/she cannot acknowledge. "What physicians cannot permit themselves to think or feel, they will not recognize and will not permit verbalized or openly felt in their patients."[37]

On occasion, too, the opening of this personal door whets the resident's appetite for a closer look. It may impart the reassurance that perhaps what lurks within is not so terrible as was feared. These residents may pursue their exploration of themselves on a more long-term basis through formal counseling, psychotherapy, or other means of self-understanding. Often, of course, the door is slammed shut. For these residents, regardless of their achievement of behavioral criteria, the remediation may very well have failed.

In addition to behavioral objectives, goals of faculty intervention with the resident might include the following: (1) To help the resident acknowledge the importance of developing the habit of self-inquiry, to see self-understanding as something more than narcissistic self-absorption, and to be able to make use of the link between self-awareness and patient awareness. (2) To assist the resident in learning how to forgive him or herself for inadequacies and mistakes made in both professional and personal spheres.[39] (3) To enable the resident to acknowledge and integrate his or her own limitations and mortality.[40] Mechanisms for accomplishing such goals include supervised exploration of family of origin issues, instructing a resident to keep a journal of thoughts and feelings connected with patient encounters, and bibliotherapy regarding the meaning of being a physician, drawing on literary as well as professional sources.

Questions for the Future

One shortcoming of our observations about residents in difficulty is that we did not systematically investigate resident, faculty, and patient responses to residents after intervention had occurred. This would most certainly represent a direction for future inquiry. Anecdotally, in our program, we could identify residents who have received intervention as falling into three categories: those who improved, those who stayed the same, and those whose symptoms and situations worsened. A next step is to understand and analyze the reasons for these different outcomes, not only in this program, but in programs across the country. Similarly, we have not elicited systematic feedback from patients about residents in difficulty. Did patients perceive these residents as dysfunctional? Once a resident has completed an intervention, do patient levels of satisfaction, compliance, return rates, etc. improve vis-a-vis this physician? These too are important questions, worthy of investigation.

Further, the issue of definition still requires clarification. In this article, we have attempted to make a beginning toward specificity and exactitude. However, we are aware that, even applying some of the exclusionary criteria listed at the start of this article, the residents we have identified as "in difficulty" do not really represent a homogeneous group (this may explain the divergent outcomes we have experienced). A more detailed, micro-analysis is required in order to more completely understand the distinctive characteristics of residents falling under this general category.

As indicated in the title, this paper represents only a beginning. Much obviously remains to be done in the area of resident remediation. Of great importance is further valid investigation and research into qualitative and quantitative assessment of residents in difficulty. Using objective, as well as subjective, measures in this process, and identifying mediating variables (demographics, the often-posited "hardiness"[42] factor, or the existence of coping resources, for example), will help avoid the hasty or inaccurate labeling of residents as "in difficulty." Perhaps of equal importance is the commitment of faculty to take the lead in recognizing the problem as one of both danger and opportunity. It is indeed a situation of danger, because what is really at stake is the quality of family physicians produced in our training programs; but it is also a situation of opportunity for making our residents and ourselves more humane and competent healers.

Appendix I

EXAMPLES OF CRITERIA FOR RESIDENT ASSESSMENT

I. RAPPORT

Awareness of patient as unique individual (knows specific personal facts)
Use of patient name
Use of family members' names
Statement of positive response (nice to see you back)
Elicits patient's expectations, reason for visit
Uses open-ended questions
Uses active listening skills
Uses paraphrasing skills
Awareness of patient nonverbal cues
Appropriate use of reassuring physical touch
Appropriate use of reassurance
Shows empathy toward patient
Reinforces patient
Makes use of self-disclosing statements
Checks patient understanding
Eye contact
Seating arrangement, body posture
Nonjudgmental attitude
Recognizes patient's feelings
Positive tone of voice
Respect for patient, concern, sincere interest
Acceptance techniques (mmhmm, I understand)
Appropriate smiling

II. PROFESSIONALISM

Appropriate dress
Systematic plan for interview (specific goals, physician agenda)
Appropriate introduction
Elicits patient rationale for visit
Comfortable, well-controlled presentation (takes charge)
Overall use of time, structuring interview (beginning, middle, end)
Respect for patient (listens carefully, acknowledges point of view, acknowledges expertise re symptoms, self)
Uses appropriate gestures, facial expressions
Refers to patient chart
Looks up information
Explains treatment and diagnostic procedures
Avoids technical jargon
Specifies future course of action
Consults with other health care providers
Appropriate closing (summary)
Adopts appropriate physician-patient role (not too friendly, not too distant)
Appropriate use of nursing, support staff
Appropriate interaction with colleagues

III. PERSONAL ISSUES

Discusses own emotional responses to patient with attending
a. Anger c. Burn-out e. Anxiety, fear
b. Helplessness d. Countertransference

Sensitive to importance of interpersonal interactions in influencing patient care cut-off
Makes use of self-disclosing statements
Can adequately comment on personal reactions during video tape review
Knows how to accept praise from patient
Can adequately deal with anger, hostility in patient
Is able to make explicit unstated feelings complicating patient care in both self and patient

Appendix II

PSYCHOSOCIAL REMEDIATION

A. For residents evaluated as deficient in interpersonal skills, a 12 hour remedial course in Interpersonal Process Recall (Kagan, 1967)[36] is required. This training develops resident self-awareness, and provides a safe environment to focus on interpersonal interactions and psychological sensitivity. This training also includes a component which helps residents identify and therapeutically manage "difficult" patients.

INTERVIEWING DOCTOR/PATIENT OBJECTIVES

1. Complete approximately 12 hours of IPR (Interpersonal Process Recall) training.
2. Be able to differentiate between the various communication modes:
   a. Exploratory
   b. Listening
   c. Affective
   d. Honest labeling (confrontive)
3. Be able to demonstrate proficiency in the appropriate use of each of these modes.
4. Be able to demonstrate response proficiency using a combination of interviewing skills to a variety of patient stimulus cues.
5. Be aware of internal emotional, physical and cognitive cues which indicate idiosyncratic responses to patients.
6. Be able to use personal reactions in a way which is therapeutically beneficial to the patient.
7. Develop proficiency in short-term management of several types of "problem" patients:
   a. Hypochondriacal
   b. Depressed
   c. Anxious
   d. Patient in Crisis
   e. Chronic pain
   f. Seductive
   g. Hostile
   h. Needy, demanding
8. Know how to structure interview including:
   a. Time management
   b. Introduction
   c. Processing problems and scanning
   d. Utilization of other resources
   e. Patient instruction/treatment
   f. Patient education
   g. Summary of session
9. Be able to critique an audio or videotape of one of their own actual patient encounters using IPR techniques.
10. Be able to give at least three examples of how the doctor-patient relationship can either enhance or detract from patient care. Possible areas might include:
    a. Compliance issues
    b. Hypochondriasis
    c. Management of patient fears

B. For residents evaluated as overwhelmed by the stress of residency training to the extent it is impeding their professional performance, an eight hour remedial program in Stresses of Residency (STFM, 1982) is required. This program uses the STFM film as a stimulus to help the resident reflect on stresses in different areas of his/her life, and also explores a range of coping strategies to use in response to these stressors.

GOALS & OBJECTIVES: RESIDENT SELF-AWARENESS

The resident should accomplish the following:

1. View the entire tape "Stress and the Resident-Physician."
2. Be able to identify the types of stressors highlighted in each vignette.
3. Be able to accurately relate those stressors to his/her current situation.
4. Be able to generate adaptive, psychologically healthy coping strategies in response to these stressors.
5. Be able to identify internal cues which are signs of stress, tension, anxiety, hostility.
6. Be aware of the resident advisory system existing in the department and how to utilize it.
7. Be able to identify other formal and informal support mechanisms available in the community to deal with personal/professional stresses and problems.
8. Be familiar with at least two basic nonpharmacological stress reduction techniques:
   - relaxation
   - hypnotherapy
   - meditation
   - guided imagery

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