ROLE OF RESIDENT ATTITUDES IN LEARNING AND USING SKILLS IN PATIENT-CENTERED INTERVIEWING

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Listen to the patient. He is telling you the diagnosis.
–Sir William Osler, 1904

Osler's wise advice to his fellow physicians, offered at the dawn of the last century, only recently has begun to be appreciated. It was not until the late 1970s that the traditional biomedical approach to diagnosing and treating illness was even questioned and the importance of the patient's perspective on health and disease considered [1]. Since then, much effort has been given to studying and advancing patient-centered models of care.

To be patient-centered means that physicians allow patients to express their needs, desires, ideas, emotions, and concerns and then use this information to help guide care decisions [2]. When communicating using a patient-centered approach, the patient initiates all new information in the conversation [2]. By contrast, when communicating using a traditional, physician-centered (disease-oriented) approach, the physician steers the conversation to elicit clinical details from the patient that can readily fit into diagnostic categories.

A powerful, humanistic rationale exists for adopting a patient-centered approach to care. In doing so, doctors hear and understand patients in a way that validates them as human beings rather than as objects of study [3]. As patients become more involved, they gain a sense of self-sufficiency and responsibility and experience greater autonomy [4]. Physicians also benefit by being able to express such human attributes as respect, empathy, humility, and sensitivity to their patients. Thus, both doctor and patient feel better [5–7].

Research further supports integrating patient-centered interviewing into the traditional, isolated physician-centered approach to the medical interview. Incomplete databases result from omitting personal information and using the high-control style of isolated physician-centered communication [8]. An early, important study by Beckman and Frankel [9] revealed that in 69% of visits, physicians did not allow patients to complete their opening statement of symptoms and concerns, interrupting after a mean time of 18 seconds. Patients were given the opportunity to state their full list of concerns in only 23% of visits. A study reported 15 years later by Beckman and others [10] revealed similar results. Patients' initial statements of concerns were completed in only 28% of visits, and physicians interrupted patients' opening statements after a mean time of 23.1 seconds. In this later study, failure to obtain the patient's complete agenda resulted in late-arising concerns and missed opportunities to collect potentially valuable information [10]. In fact, physician-centered interviewing has been shown to elicit only 6% of the primary problems that were ultimately determined to be psychosocial [11]. These and other studies reveal that most patient data from isolated physician-centered practices are physician determined, skewed toward the doctor's concerns about physical symptoms, and directed away from the personal dimension and the patient's concerns [12].

Patient-centered interviewing reveals much of the physical symptom data ordinarily obtained via doctor-centered inquiry [13] as well as some data *not* obtained using this approach—information that is often valuable for diagnosing organic diseases [14]. A crucial attribute of a patient-centered approach is that it quickly elicits both personal and symptom data needed to develop a relevant biopsychosocial description of the patient [15]. These data efficiently point to the most important problem the patient has at a given time [15,16]. Furthermore, research shows that patient-centered interviewing does not take extra time [17].

Recent reviews provide significant evidence that patient-centered interviewing offers additional benefits for clinicians, patients, and the health system in general [18–20]. Perhaps the most compelling benefit is improved clinical outcomes, including better blood pressure

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Table 1. Basic Skills for Patient-Centered Interviewing

Nonfocusing open-ended skills
Silence
Nonverbal encouragement (head nodding, leaning forward)
Neutral utterances, continuers ("um-hum")
Focusing open-ended skills
Reflection, echoing (patient says, "I'm worried;" physician echoes, "Worried?")
Open-ended requests ("Can you say more about that?")
Summary, paraphrasing
Emotion-seeking skills
Direct ("How did that make you feel?")
Indirect (self-disclosure, impact on life, impact on others, belief about problem)
Emotion-handling skills (N U R S)
Naming, labeling ("You sound sad.")
Understanding, legitimatizing ("I can sure understand why…")
Respecting, praising ("You have been through a lot.")
Supporting, partnering ("I am here to help you any way I can.")

Adapted with permission from Smith RC. The patient's story: an evidence-based method. 2nd edition. Philadelphia: Lippincott Williams & Wilkins; 2001:17.

and diabetic control [21], improved perinatal outcomes [22], shortened and less complicated postoperative courses [23–25], and improved cancer outcomes [26–29]. Patient-centered approaches also are associated with improved patient compliance [7,30,31], greater patient knowledge and recall [6,7,30], and increased patient satisfaction [6,7,30,32]. Finally, fewer malpractice suits [33–36] and decreased "doctor shopping" [37] are observed when patient-centered communication is integrated with a physician-centered approach.

Effective physician-patient communication is recognized as an essential skill for physicians entering practice. The Accreditation Council for Graduate Medical Education requires residency programs to certify that their graduates demonstrate competence in—among other interpersonal and communication skills—the use of effective listening skills as well as nonverbal, explanatory, and questioning skills to elicit and provide information to patients [38]. Many medical educators would agree that these are basic patient-centered interviewing skills (**Table 1**) physicians need to complement a traditional disease-oriented approach to information gathering [2,39–42]. Ideally, dialogue during a clinical encounter should begin with a patient-centered approach and then intersperse patient-centered with doctor-centered interviewing to obtain specific data not already given and important to making a diagnosis.

This report describes two family practice educators' (JO, KK) experience teaching residents patient-centered interviewing using a five-step method developed by one of the authors (RCS) and several of his colleagues. This method was studied previously in first-year family practice and internal medicine residents and was found to be effective in improving the learners' knowledge about, attitudes toward, and skills in patient-centered interviewing [43–45]. Our experience to date allows us to recommend this approach as a practical, workable template for primary care educators. We were surprised to observe the central role that attitudes played in learners' interest in acquiring and deploying patient-centered skills. We focus upon this aspect of our experience.

Background

Setting

Sparrow Hospital family practice residency program is affiliated with Michigan State University College of Human Medicine and currently consists of 32 residents. The residency experience includes clinical rotations at the hospital, a large outpatient clinic adjacent to the hospital, and a small rural family practice clinic 15 miles away. The second and third years are a continuous series of 4-week rotations, each consisting of 2 weeks in one of the clinics followed by 2 weeks in a non-clinic setting (eg, inpatient family medicine service, elective). During clinic weeks, residents see patients from 8:00 until noon and from 1:30 until 5:00 every day except Wednesday. Grand rounds are held 8:00 to 9:00 each Wednesday morning; thus, residents have shorter clinic hours that day.

Our first experience with the curriculum in patient-centered interviewing occurred from October 2000 to March 2001 and involved 13 third-year residents. The training program, which was required for the residents, was designed to run longitudinally over 20 weeks (5 rotations), for a total of 28 contact hours. In its initial cycle, the program was funded by Capital City Consortium as part of a state of Michigan Medicare grant to address resident education in managed care issues. Although we have since completed a second cycle of training, this report documents our initial experience.

Goals and Objectives

Our goals were twofold: upon completion of the program residents will be both *willing* and *able* to use an integrated patient-centered and physician-centered

Table 2. Objectives for Skill Development in the Five-Step Patient-Centered Interviewing Method

At the conclusion of training, the resident will be able to demonstrate the following skills in an integrated manner during encounters with a broad cross section of patients:

Step 1. Setting the stage
- Welcome the patient
- Refer to the patient by name
- Introduce self and identify specific role
- Ensure patient readiness and privacy
- Remove barriers to communication
- Ensure comfort and put the patient at ease

Step 2. Chief complaint/agenda setting
- Indicate time available
- Indicate own needs (eg, obtain history, perform physical examination)
- Obtain list of all issues the patient wants to discuss (eg, specific symptoms, requests, expectations, understanding)
- Summarize and finalize agenda; negotiate specifics if too many agenda items

Step 3. Nonfocused interviewing
- Use open-ended beginning question
- Use nonfocusing open-ended skills: silence, neutral utterances, nonverbal encouragement
- Use focusing open-ended inquiry when needed to get patient talking: echoing, summary, requests
- Use closed-ended questions for clarification
- Obtain additional data from other sources: nonverbal cues, physical characteristics, autonomic changes, accouterments, environment

Step 4. Focused interviewing
- Obtain personal description of the physical symptoms (focusing open-ended skills)
- Extend the story to the broader, personal context of the symptoms (focusing open-ended skills)
- Develop a free flow of personal data (focusing open-ended skills)
- Develop an emotional focus (emotion-seeking skills)
- Address the emotion(s) (emotion-handling skills)
- Use the cycle of "core dynamic skills" repeatedly (focusing open-ended skills, emotion-seeking skills, emotion-handling skills) to better identify and deepen the story
- Conclude and address other current issues

Step 5. Transition to the doctor-centered interview
- Briefly summarize information obtained from the patient-centered interview
- Check accuracy
- Indicate that both the content and style of inquiry will change if the patient is ready

Adapted with permission from Smith RC. The patient's story: an evidence-based method. 2nd edition. Philadelphia: Lippincott Williams & Wilkins; 2001:36,40,45,48,65.

approach to the medical interview. Meeting these goals required a focus on attitude as well as skill development [46,47]. We believed the patient-centered dimension of interviewing was the most essential skill to be taught because residents already were familiar with doctor-centered interviewing to make a disease diagnosis. **Table 2** summarizes our objectives for skill development in the five-step patient-centered interviewing method. Our objectives for attitude development were for residents to 1) acknowledge personal reactions to patients that may have an adverse impact, 2) recognize that patient-centered interviewing skills would help them be more effective physicians, 3) believe that such skills would help them develop better relationships with patients, and 4) value rather than fear the emotions that patients bring to the clinical encounter.

Core Components of the Program

Teaching Sessions

The initial 13 learners were divided into groups of 6 and 7. Each group attended teaching sessions for 2 consecutive clinic weeks and then was off 2 weeks, during which time the other group attended. Over the course of 20 weeks each resident attended 10 sessions. Most sessions were held on Wednesday mornings after grand rounds in small meeting rooms near the central clinic.

Prior to the training, residents received a syllabus containing an orientation letter that explained the program, a schedule for the curriculum, and objectives for the learning experience. An instructional text [48] detailing the five-step patient-centered interviewing method was provided (via the grant) to each resident.

Two introductory teaching sessions per group were held on Tuesday afternoons. These lasted 3 to 4 hours each and focused on the theoretical background for patient-centered interviewing and the specifics of the five-step method. In taking a learner-centered approach, we sought to mesh faculty and resident objectives for the learning experience. Thus, we spent time initially explaining our goals for the curriculum, discussing what residents wanted to learn, and working through resident objections to the program. During the two introductory sessions we also viewed a videotape [49] demonstrating the five-step method.

Later sessions were spent practicing the specific skills of patient-centered interviewing and critiquing residents' interviewing performance. These sessions also were used for didactic and interactive discussions on physician-patient communication topics of interest to the residents (eg, somatization, sexuality, difficult patients). For example, we devoted two sessions per group to discussing how patient-centered interviewing skills can be used to communicate more effectively with difficult patients or patients with personality disorders.

Critiques of Interviewing Skills

Three methods were used to practice patient-centered interviewing skills—role-play, tape-recorded interviews, and live patient interviews. When residents practiced during group time, their skills were critiqued by observing residents and faculty. Each resident was subject to at least four critiques of their use of the skills. A critique form, based on the items in Tables 1 and 2, was distributed prior to an interview and used as a guide to monitor the interview and provide feedback.

Role-play. Role-play was the first method used for practice. The faculty (JO, KK) initially engaged in role-play to illustrate the skills. We demonstrated both "good" and "bad" techniques, which allowed residents to become comfortable in giving feedback and allowed us to model humor and grace in receiving it. The skills were then broken down and practiced by residents in groups of three—an interviewer, an interviewee, and an observer. Later, after residents were more comfortable with the skills, we did large group role-plays with critiques afterward.

Tape-recorded interviews. Prerecorded interviews also were used early in the training program. Residents were asked to tape a conversation with a friend or spouse in which they used the skills listed in Table 1 and then to review the tape on their own and with another resident for feedback. The group then critiqued some of these tapes at the next teaching session. During the 20-week program, each resident was required to bring a tape-recorded patient interview to an assigned session for the group to critique.

Live patient interviews. Live interviews with patients occurred in three ways. One of the faculty (KK) arranged for some of her patients from the main clinic to be interviewed in front of the group. After a resident volunteer conducted an interview, the patient was thanked and dismissed and the faculty and observing residents critiqued the interaction. Live interviews also occurred while on rounds during an inpatient service. First, the faculty obtained the patient's permission for the interview, then the group entered the patient's room and observed a resident volunteer interview the patient. Afterward, the group thanked the patient and went to a room in the hospital to critique the interview. Finally, while precepting during clinic, the faculty sought opportunities to observe residents interviewing patients and to model interviewing skills in a one-on-one fashion.

Protocol for critiques. Prior to conducting an interview in front of the group, a resident interviewer would determine which skills to practice. The critique typically began with a faculty member asking the resident to describe her personal reaction to the patient and the interview overall. Then, the resident was asked to assess her success with using whatever skills were being practiced. Finally, resident colleagues and faculty provided feedback. For initial critiques, resident colleagues were assigned specific areas of the basic interview to evaluate, such as being open-ended, eliciting emotion, using emotion-handling skills, probing the depths of the patient's story, structuring talkative patients, or getting reticent patients to talk.

We encouraged residents to give feedback in behavioral, impersonal terms, to limit feedback to two or three items that could be accomplished, and to frame critiques positively in the context of what the learner was doing well [50]. Although faculty initially took a major role in these group sessions, over time, resident colleagues provided much of the feedback. Faculty monitored and open-endedly explored the interviewer's reactions during the critique, helping raise awareness about interfering issues such as being overly controlling or too passive. At the end of the critique, the interviewer was encouraged to identify skills he wanted to work on for the next exercise.

Group Work

Group sessions were used as an opportunity for residents to discuss their personal reactions to patients or to residency experience in general, such as feelings about faculty, scheduling, call, the patient-centered interviewing curriculum, or any aspect of the residency

program. During these discussions, residents often voiced strong reactions about not being able to use the skills effectively because of limited time (eg, when patients were scheduled too tightly in clinic) or fatigue (eg, when they had been on call the night before). Such issues were explored open-endedly, with faculty and residents supporting each other using the same skills being taught for use with patients. In general, support group principles were used to guide these discussions (eg, respecting confidentiality, offering only positive feedback and support, speaking for oneself and only when ready, expressing current emotional reactions) [51].

Resident and Faculty Experience: Some Highlights

No formal evaluation was conducted before or after the first cycle of training, so we cannot provide conclusive results of the program's effectiveness. However, the following highlights of personal and group experiences are offered to illustrate the struggles, failures, learning, and self-discovery that occurred.

Putting New Skills to Work

On a busy clinic day during the 20-week program, one resident saw an add-on patient with an upper respiratory complaint. A nurse's note on the visit sheet indicated that the patient refused to try over-the-counter (OTC) remedies. The resident expected she would have the usual troublesome, time-consuming debate about the use of antibiotics for viral syndromes. Despite believing that she "already knew why the patient was here," the resident decided to try her newly acquired skills in patient-centered interviewing. To her surprise, the patient's primary wish was to understand which OTC medication he could use that would not adversely affect his hypertension. Continuing the open-ended interview, the resident learned that the patient was very concerned about dying from a stroke because, as he soon confessed, he had taken an OTC preparation and then developed a headache. Further exploring his concerns using a patient-centered approach, she also learned that he was motivated to do home blood pressure monitoring. The resident was surprised at how much valuable information she gleaned from the patient that she would have missed had she pursued her own agenda for the encounter. She realized, too, how little time patient-centered interviewing took and how this approach helped her focus her patient education efforts on an area where the patient was likely to respond (ie, self-management of hypertension, home monitoring).

Addressing Common Causes of Discomfort with Patients

During group sessions, several residents expressed a desire for greater comfort and confidence in addressing certain topics raised by patients, such as addiction, sexual problems, pain, spiritual issues, and death. For example, when patients raised sexual concerns, residents seemed to realize their discomfort caused them to avoid these issues and ultimately resulted in deficiencies in helping their patients. We learned that besides their expected discomfort discussing sexual matters, residents were even more distressed about being unable to medically address such complaints (eg, to recommend management for impotence or painful intercourse). They indeed were taught that it is appropriate to deal with sexual problems but felt frustrated in lacking adequate medical knowledge to proceed. In addition to responding empathically, we addressed the practical issues residents raised, discussing specific medical treatments, providing resources, and helping residents identify experts to whom they could refer patients when needed.

Inappropriate sexual expressions by patients also were a source of discomfort, anxiety, and irritation for residents. For example, in one group session, a female resident revealed that a sexual remark from a male patient had made her "feel dirty." The experience caused her to then withdraw—a reaction she was able to understand only after discussing the encounter with her resident colleagues. In particular, the group supported her and accepted her feelings, rather than arguing that they were wrong. By sharing their own similar reactions to such encounters, others in the group helped the resident realize that her feelings were a normal, realistic response to a negative situation. The group also helped her to develop effective means of responding to similar situations in the future (eg, setting limits and guidelines with difficult patients) and to realize that she also had rights and needs during patient interactions.

Learning from Others: Even Teachers Struggle

Group sessions provided an opportunity to analyze how integrating patient-centered interviewing might have improved the outcome of recent patient encounters experienced by members of the group. During one session, a personal experience was shared by one of the faculty. JO reported making small talk with a patient while removing a wart only to have the "hand on the door knob" phenomenon occur as he went to exit the room. In the final moments of the visit, the patient asked if he could raise another issue—his father's recent heart

attack and his own fears about this. JO then took an additional 15 minutes to address what could have been discussed during the procedure if he had been open-ended and patient-centered and set an agenda at the outset of the visit. Resident feedback later revealed that one of the most effective aspects of the 20-week training experience was this ability to share one's own foibles and to learn from them. Establishing a safe environment for these discussions, where residents were free to talk without fear of criticism, was key.

Gaining Self-Awareness: One Resident's Personal Benefit

Initially, some residents viewed the time invested in the interviewing process as "a waste." However, as residents discovered that patient-centered interviewing actually enhanced their clinical skills, they responded more enthusiastically. One resident commented that he had particularly enjoyed the group sessions because of the mutual sharing of personal stories about patients, the ability to express feelings in a safe environment, and the general support offered by the group. After the sessions, he always felt good and less alone and burdened, having been reassured by learning that others experienced similar feelings and reactions. This resident later described the time invested improving interviewing skills as a "luxurious opportunity" he would not have after graduation, and he expressed concern that an office practice would be much more isolated than his residency experience. As a result of his experiences during the 20-week program, the resident planned to deliberately seek a practice environment that would foster such camaraderie.

Gaining Confidence Teaching a New Curriculum

As inexperienced teachers of a new curriculum, we gained important self-awareness as well. At times, early feelings of inadequacy made us reluctant to push the residents along, leading us to become co-conspirators in avoiding difficult role-plays and using live patients effectively. However, by having two of us (JO and KK) teach together, frequently debriefing each other, and having our own mentors (RS and KL) available as resources, we were able to identify and effectively address some of these problems.

At one point, two sessions had passed without reviewing a single taped interview or performing any role-play of the skills we planned to teach. We were impatient to cover the curriculum and felt we were deficient in getting residents to practice the new skills. However, through our own debriefing, we realized that the residents were afraid to practice in front of others and to expose themselves to possible criticism. Rather than acting on our perceived need to teach the specific skills right away, we remained learner-centered. First, we provided the focus for sessions by ourselves doing role-plays related to specific skills and bringing our own tape-recorded interviews for critique by the group. By the end of the next session, some residents were volunteering to do role-plays and some agreed to bring their own tapes of clinic patients for the following session.

Observations and Lessons Learned

We learned several lessons from this initial effort to integrate a patient-centered interviewing curriculum into our family practice residency program. To our surprise, the didactic component of teaching the five-step method was not our most difficult task. The far more difficult issue was helping residents overcome attitudinal resistance to learning and, more importantly, using patient-centered interviewing skills—particularly when not being observed by faculty. We did not anticipate the degree of personal bias and resistance against the curriculum that our residents initially demonstrated.

Overcoming Attitudinal Resistance

Although residents generally accepted the idea that patient-centered interviewing was superior to an isolated doctor-centered approach, many believed they were overly taught the biopsychosocial model and were already practicing these concepts. About half believed that continuing to spend time on such training was of no benefit and would "waste" valuable clinical training time by "taking away opportunities to learn from patients in the clinic." Most felt that as long as they were generally pleasant, respectful, and polite to patients during an encounter, this alone would result in patient-centered information and the benefits therein. All believed that using the patient-centered skills would take them more time to arrive at the same biomedical conclusion. In short, they initially believed that being patient-centered was a nice idea but not very realistic for actual practice.

We additionally observed attitudinal resistance to some of the teaching methods. For example, some residents resisted role-play as "not real-life" or "artificial." Others objected to tape-recording their own patients, saying it "poisoned" the encounter and produced an unrealistic setting. Still others felt that training interviews conducted on inpatients—for whom the residents had no ongoing care responsibilities—were not "genuine." Some residents also demonstrated personal bias against addressing patients' personal or psychosocial issues (eg, related to AIDS or alcoholism).

We sensed that some of the residents' objections to the teaching methods and the curriculum were a defense against being placed in a situation where they would be observed and evaluated on skills that, as one said, "we should already have mastered." We took these objections seriously and realized that teaching beyond simple skills acquisition would require attitudinal buy-in from learners as well as overcoming personal bias about patients and about learning psychosocial medicine. Over time, we overcame much of the resistance initially demonstrated by residents, with attendant improvement in learners' interviewing skills. Several factors were essential to this effort.

Being learner centered. Facilitating attitudinal change required a safe, respectful environment. Residents' openness and expressivity were fostered, appropriate to the situation, by our own self-disclosure and sharing of personal vulnerabilities and uncertainties. A learner-centered approach was integrated with a teacher-centered approach to ensure buy-in from the learners and to model the basic communication principles we were teaching; that is, we listened to the residents' objections, acknowledged their emotions, and handled them with the same relationship-building skills we were teaching them to use with their patients. This facilitated learners' identification of their own needs and interests [52]. Throughout the training we gave high priority to facilitating residents' self-awareness of attitudes, emotions, and thoughts that could interfere with physician-patient communication [48,53–55]. In being learner-centered, we addressed residents' immediate concerns about interviewing or related topics that arose, including non-interviewing issues important to residents and their practices (eg, how to make psychiatric referrals, specific techniques for detoxification from addicting medications, what to do when a patient raises spiritual issues, how to diagnose and treat depression and anxiety, treating sexual problems).

Relying on the teacher-learner relationship. We often drew on the strength and depth of the relationships we had developed with the residents in other settings. Using learner-centered listening and drawing upon the "interpersonal capital" we had built up with the residents, we were able to convince them to give the curriculum a chance and we ultimately inspired most to participate actively in training. As residents experimented with the concepts and methods, they found that the quality and content of the information obtained from patients was "actually better." They found they could efficiently address a patient's core concerns, especially if they actively elicited the patient's agenda at the beginning of the encounter.

Demonstrating skills in clinic. It was especially beneficial to demonstrate how patient-centered interviewing could be an efficient and useful tool for managing an encounter that a resident was struggling with using a predominantly doctor-centered method. For example, during clinic one resident presented a purely biomedical disease story to one of the faculty regarding a patient with congestive heart failure. The resident was confused about what to do for the patient because he did not look sick. When the preceptor inquired about the factors motivating the patient to come to the office, the resident was uncertain. Respectfully and tactfully, the preceptor joined the resident in the patient's clinic room to observe the resident's efforts to determine why the patient had come and then to demonstrate some additional skills in patient-centered interviewing. The preceptor quickly discovered that the patient wanted to know whether he could vary the dose of his diuretic depending on his fluid status or should call the office. The resident indicated feeling supported—that he had learned something—and he was impressed with how quickly the patient could be understood.

Some Changes

We have made some notable changes in subsequent cycles of the training program based on our initial experience with the curriculum. We have expanded the teaching to include all second- and third-year residents and divided the residents into four groups; we meet with one group each week. Thus, all second- and third-year residents attend one Wednesday morning teaching session every 4-week rotation, for a total of 24 sessions over 2 years. This schedule allows the curriculum to be more completely longitudinal over the course of residency and encourages residents to continually challenge themselves to improve their communication skills. We also have greatly cut back on the time spent on introductory material, from 6 to 8 hours in the initial cycle to 2 hours. The initial group did not find the theory behind patient-centered interviewing interesting or useful when presented outside the context of actual patient encounters. We now call upon the theoretical background material to answer questions as they arise in discussions or to illustrate specific points.

In summary, we observed that teaching patient-centered interviewing skills is a process that requires time, practice, coaching, and support. Critical factors for obtaining learner buy-in were to share our own enthusiasm for the method as well as real examples of how we apply the skills in our own practices, including our personal struggles and failures to be patient-centered.

Recommendations to Others

The longitudinal component of the teaching was key. Residents needed time to realize that biopsychosocial training beyond what they absorbed in medical school was, in fact, helping them develop as physicians. They ultimately accepted the patient-centered care approach and realized that this type of communication does not always come naturally, nor is it simply a matter of being pleasant. Once residents accepted the method, they quickly learned the skills. We fostered this acceptance by minimizing experiences (role-play, taped interviews) residents felt were a deviation from real life in the clinic or hospital. Residents preferred to try new skills with real patients in clinic, which ultimately aided our teaching efforts because residents observed the benefits of patient-centered interviewing in action. This, in turn, led residents to be more receptive to seminar work and to learning additional skills. Importantly, each resident came to this acceptance at a different pace, which, as teachers, we learned to respect.

We believe that two faculty were essential to this effort and that frequent debriefings provided not only insight and self-awareness but also mutual support for what was a new venture for both of us. Involving two faculty members also signaled to residents that the residency program and the director considered this material important enough to commit resources to teach it. Residents particularly valued that, as physicians, we face the same patient situations they face and experience the same difficulties integrating a patient-centered approach. Demonstrating a concern for treating the "whole patient" was key to our success in conveying the practice of biopsychosocial medicine. While we value and work often with behavioral scientists, we tried to convey that physicians should be the front line in addressing patients' problems, referring only when necessary.

Conclusion

To effectively investigate patient complaints, practicing physicians must be able to integrate patient-centered skills with doctor-centered skills. Teaching patient-centered interviewing is possible, and our experience using a specific, five-step method appears to have been successful. Skills training, however, is not enough. Residents' negative but understandable attitudes must be addressed concomitantly. We were encouraged that by using our own empathic skills we were able to meaningfully address attitudinal resistance. We propose that training residents in interviewing and the physician-patient relationship requires attitudinal training as well as skills training, first establishing basic skills and progressively increasing emphasis upon attitudes.

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