Resident Self-Awareness through Group Process

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Too frequently the behavioral sciences have been conceived as another specialty from which will be derived new techniques to extend the physician's armamentarium. The doctor/patient relationship as well as referrals and consultations have been assumed to be reducible to ritualized protocols and treatments. The personality of the physician and his interpersonal style both with patients and colleagues have often been ignored as being beyond the purview of professional concern. Yet the person of the physician is subject to the influence of colleagues and patients as well as their factual reports. Traditionally, the physician has not received training to allow him/her more objectively to understand the dynamic social processes through which health care planning is formulated, delivered, and received. With such social skills training the physician is in a better position to understand the dynamic processes within the family itself. Both health-care teams and families exhibit similar problems with parental authority, sibling rivalry, differential learning styles, and different career priorities. It is, therefore, essential that an adequate behavioral science program be structured to include learning experiences in which the physician can gain a greater awareness of self, interpersonal style, professional role, and group dynamic processes. Simulated health-care team exercises and encounter groups are two avenues through which such learning can be approached.

Health-care simulations and basic encounter groups, structured and unstructured, provide the necessary foundation for allowing the young family physician to focus attention on self and interpersonal style. If this learning experience is provided, the resident is then in a better position to review the quality of interaction with the patient and family as well as the quality of his/her interprofessional collaboration. The resident's self-awareness as a professional cannot truly focus until feedback from colleagues and fellow health-care workers is given attention. To facilitate this kind of professional and personal growth, group process activities have been incorporated in residency training in the Department of Family Practice at the Medical University of South Carolina.

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Health-Care Simulations

During several orientation programs in the past five years, a "Patient/Family Care Situation" was simulated involving two or three hypothetical health-care teams. The team contained as many as six scripted participants. On occasion two persons could be given the same script. The hypothetical teams were composed of family practice residents, nurses, physician assistants (MEDEX), and pharmacists. The scripts developed by a former faculty member, Roby M. Kerr, PhD, were designed to give the participants data comparable to that which they might have acquired about a patient and family in the role of a nurse, social worker, doctor, physician assistant (MEDEX), pharmacist, psychologist, or aide. The participants were asked to read the script, assume the role for which they were presently preparing and then rank order from 1 (should be done first) to 10 (should be done later) the health-care actions listed on a separate sheet. The sheet of "Health-Care Actions" contained 17 items. The participants could add as many as four items of their own. Each person was given ten minutes to complete this ranking privately and the "Health-Care Actions" sheets were then collected.

The hypothetical team was then given one "Health-Care Actions" sheet to complete as a group in a similar manner. After 30 minutes, this "Health-Care Actions" sheet was collected and the group was asked to evaluate itself. How satisfied was each person with the professional quality of the solution the group proposed? Did each profession feel that it was given a fair hearing by the group? What characterized the decision-making process of the group? What kinds of leadership did different members exhibit? What individual behaviors did group members find most helpful? Did the group discover that each member had some similar data and some different data on the simulated patient, family, and social setting? These and many other questions were raised with each hypothetical team. These questions caused the group members to become more conscious of group process, professional roles, and interpersonal style. Through such simulation the resident is given the opportunity to focus on more than the question of patient/family management which may otherwise preempt his/her attention to his/her own feelings as a physician and as a member of the health-care team.[1,2]

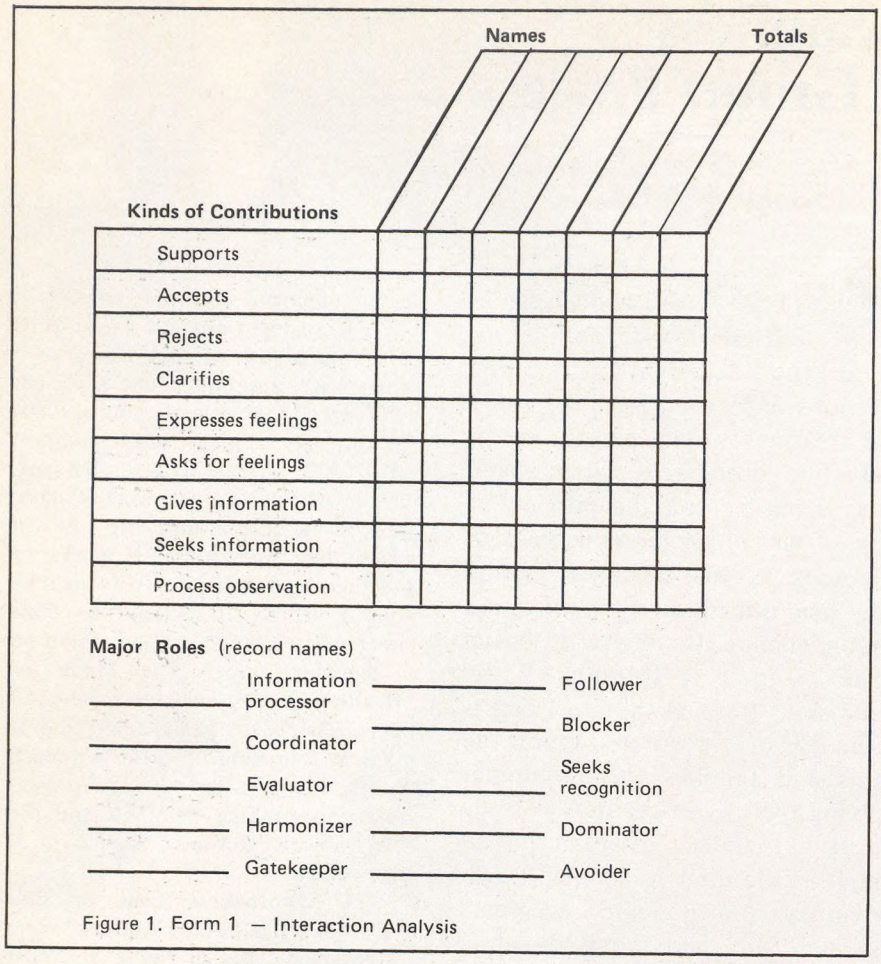

Figure 1. Form 1 — Interaction Analysis

The Basic Encounter Group: Structured

During every orientation program, 2½ days are spent in a basic encounter group. At this point in the sequence of the orientation program the residents have completed a series of psychological tests, received feedback on these tests, and discussed them with their colleagues. They will have completed a one-day session in lecture and discussion on transactional analysis (TA), and 2½ days of counseling skills training focused around client-centered therapy. There will also have been half-day presentations on each of the following psychotherapies: Adlerian, behavior modification, and Gestalt. Needless to say, the 15 residents at this point will have gained more than just passing acquaintance with their colleagues. Several days before the encounter group each resident is asked to read Rogers' article, "The Basic Encounter Group and Its Process."[3]

The first day of the basic encounter group is structured in such a way as to create a series of group-on-group exercises. One of the facilitators pulls out of the inner group and along with five or six volunteers constitutes an outer group of process observers. These observers take on different roles for a half-hour observation period. Two of the observers are asked to do a simple interaction analysis on the response of the participants in the inner group. Form 1 illustrates the categories that are used in judging the types of interactions. At the conclusion of the half-hour period, a summary of responses is made in the different categories such as "accepts," "rejects," "clarifies," etc. The two outer group members who elect to do this observe complementary halves of the group. They are then asked to assign each person a role, or roles, that most objectively characterizes his or her function in the inner group.

Two other residents are asked to do a sociometric analysis of the process in the inner group. Here, Form 2 is used which allows the resident to indicate by a series of arrows who speaks to whom or who speaks to the group in general. To show this kind of interaction a vector is simply drawn from one person to another, or from one person to the inner circle called "Group." Additional comments are simply denoted by the addition of an arrowhead to the already existing vectors. Following the half-hour period of observation, the resident observer is in a position to analyze the number of comments made to people vs the number of comments made to the group. In addition, it is possible to note the number of comments made to and from each person within the inner group.

The fifth (and sixth) observer is asked to do a Time Structure and Theme Analysis of the inner group process over the half-hour period. The basic time structures of withdrawal, rituals, pastimes, activities, games and intimacy are defined in the pamphlet, *Introduce Yourself to Transactional Analysis,* that all residents have been asked to read.[4] These concepts also have been reviewed in the one-day lecture and discussion on TA which preceded the basic encounter group. The residents who assume this responsibility will be asked during every two-minute period to give their assessment as to what time structure the group is in and also to note the major theme or themes discussed during that two-minute period. Form 3 illustrates the Time Structuring and Theme Analysis format.

During the course of the first day and a half every person in the group is asked to serve for one half hour as a process observer of the inner group's activities. The inner group is assigned no particular theme or topic with which it must deal; it is assigned no task. Following the 30-minute process observation period, the observers leave the room and synthesize as well as they can what their experience has been of the inner group. The inner group is also asked to stop at that point whatever discussion it has been involved in and begin to reflect on the experiences of each of its members over the past half hour. The observers are then asked to come back in the room. They are given an uninterrupted period of time in which they can

present to the inner group their data, interpretations, and impressions of the half-hour structured analysis of the group's process. A discussion then follows with all members freely interacting.

The underlying purpose of the first day and a half basic encounter group is to illustrate that social process and psychological dynamics are two very different phenomena. Such an experience allows the resident a firsthand encounter with the concepts of membership, data flow analysis, decision-making processes, group values or norms, and task orientation vs maintenance. Each person also can begin to see more clearly how his/her interpersonal style may affect him or her personally and how it affects the group. It is believed that such an experience also sets the foundation for the doctor coming to understand more nearly what family process is like and the processes that characterize the health-care team itself.[5-11]

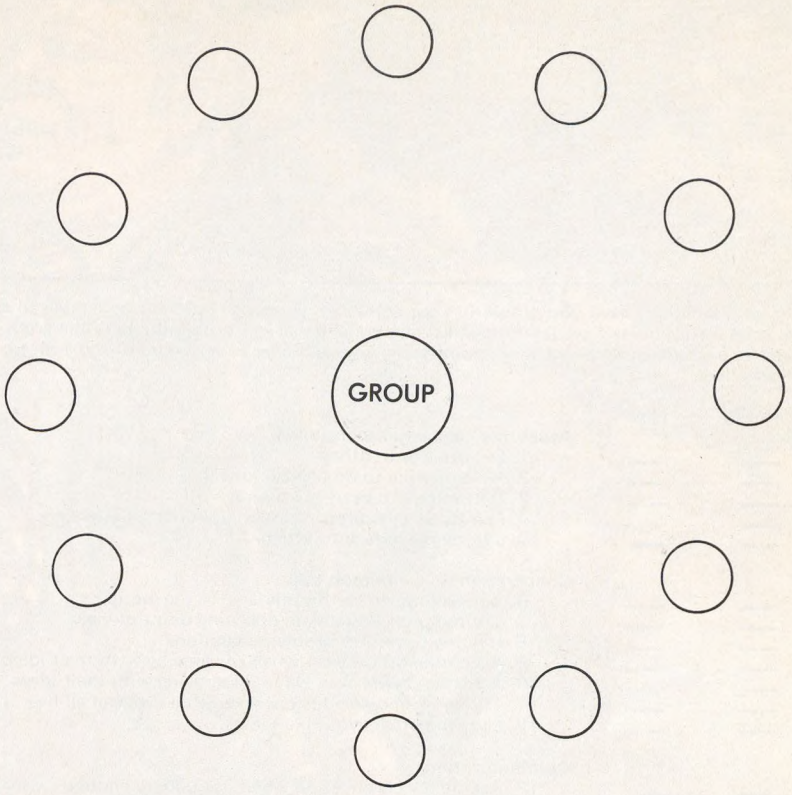

Figure 2. Form 2 — Sociometric Analysis

The Basic Encounter Group: Unstructured

The second day of the basic encounter is a totally unstructured experience in which whatever concerns a resident or residents is freely accepted as part of the day's agenda. The only explicit norm for behavior established is that as often as possible the resident will be asked to stay in the "here-and-now." That is, the second day of the basic encounter group is not intended as a therapeutic session to which persons bring longstanding problems, either professional or personal. Rather, it is an encounter among the residents and the staff with no differential status being assumed by the staff. Over the past three years, the basic encounter group has been rated by the residents as one of the most significant learning aspects of the entire two-month orientation program. Other residents have described it as perhaps the most significant learning experience in their educational career. Following the two-day encounter group each resident is asked to read Baret's article, "Therapeutic Intervention and the Perception of Process."[12]

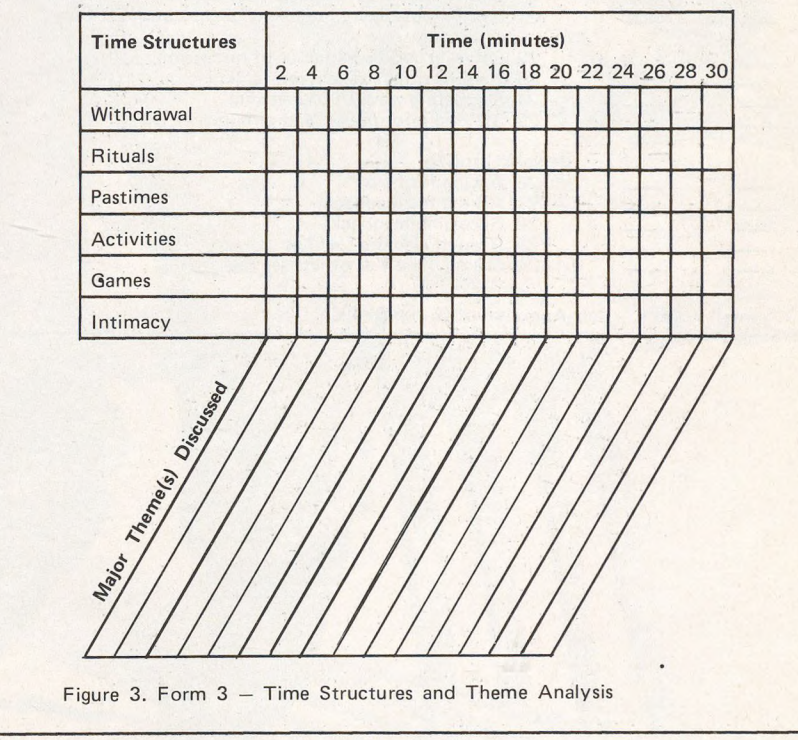

Figure 3. Form 3 — Time Structures and Theme Analysis

In your opinion, have you grown in your ability to work with others as a member of a group? Rate yourself on the following characteristics as you were initially in the group and as you are now. Use a seven-point scale, where 7 means "very much" and 1 means "very little."

Initially	Now	
		Accepting personal responsibility
___	___	1. Initiating with others
___	___	2. Volunteering to do needed jobs
___	___	3. Informing others of my desires
___	___	4. Frankness in expressing ideas, opinions, and feelings
___	___	5. Offering feedback to others
		Cooperation on a common task
___	___	6. Actively facing conflicts arising in the group
___	___	7. Trying to understand an opposing point of view
___	___	8. Helping to resolve problem situations
___	___	9. Accepting others even when disagreeing with their ideas
___	___	10. Assisting others even when disagreeing with their ideas
___	___	11. Trying to find conclusions with which we can all live
___	___	12. Showing others you like them
		Communication
___	___	13. Asking for clarification when not understanding
___	___	14. Restating the comments of others when wanting to be sure of understanding
___	___	15. Listening to others attentively
___	___	16. Looking for non-verbal cues
___	___	17. Encouraging others when they seem to want to express themselves
		Problem-solving and decision-making
___	___	18. Keeping a minority view before the group
___	___	19. Suggesting new ways of doing things
___	___	20. Clarifying the contributions of others
___	___	21. Withholding hasty judgment of the contributions of others
___	___	22. Offering good summaries of discussions
___	___	23. Helping others to stay on target
___	___	24. Suggesting ways of proceeding
___	___	25. Seeking information and opinion
		Personal growth
___	___	26. Asking for help
___	___	27. Asking for feedback
___	___	28. Receiving feedback
___	___	29. Recognizing my feelings
___	___	30. Seeing myself as others see me

Figure 4. Form 4 — Self-Appraisal of Group Skills

Comment

At the close of the two-month orientation program when completing a Counseling Profile post-test, the residents are asked to complete the Self-Appraisal of Group Skills (Form 4). The resident is asked to evaluate how he sees himself "now" and how he saw himself "initially" on entrance to the residency training program. In 1975, for all persons on all items there was a significant change noted beyond the .001 level of significance. With the exception of three residents, all residents, taken individually, on all items showed a significant change at the .02 level. Thus, we believe there is objective evidence to support the assertion that the health-care simulations, and basic encounter group, structured and unstructured, provide a rich growth experience for the resident. This growth experience contributes to the clarification of the resident's professional role, interpersonal style, and self-awareness.

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Continued from page 621

of the following conditions, subgrouped by age, sex, race, geographic area, income, and education: Blood Pressure,[4] Heart Disease,[5] Coronary Heart Disease.[6] Hypertension,[7] Osteoarthritis,[8] Rheumatoid Arthritis,[9] Blood Glucose,[10] Hematocrit,[11] are available. While from the Health and Nutrition Examination Survey,[12] anthropometric and vitamin surveys of children and adolescents have been made.

Problems that could provide good quality of care indicators would be problems such as hypertension (studies from the Veterans Administration[13,14] have shown the value of intervention), rheumatoid arthritis, coronary heart disease, and iron deficiency anemia. These could be used far more suitably to illustrate the quality of care of ambulatory practice than the ones suggested.

Studies presented at the Second National Conference on Hypertension in New Orleans in 1976 showed that of all hypertensives in the US (approximately 15 percent of the adult population over 18 years of age), only half have been examined for hypertension, of these only half have been placed on treatment and of these, only half are under satisfactory control. This fact also suggests highly unsatisfactory quality of care of a common remediable condition.

Dr. Froom states in his reply that he does not think physicians' practices really represent a biased selection from the community. All practices together may not, although the need for publicly funded medical clinics suggests otherwise. It is highly likely that individual practitioners' practices are biased. The data from national surveys and results of long-range prospective studies have shown these major disease problems are highly prevalent, cause major disability, are amenable to both preventive, remedial and, in some cases, restorative therapy, and meet criteria for quality of care assessment that have been established in national trials.

Continued on page 690

Continued from page 688

If Dr. Froom would be kind enough to continue the dialogue to allow more discussion, I hope other readers will also contribute. The discussion illustrates the need for far more research and collection of data for a variety of ambulatory care problems.

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The previous letter was referred to Dr. Froom who replies as follows:

To the Editor:

In reply to Dr. Buttery's letter, I would make the following points:

1. I agree that assessment of quality of care is important, although valid and tested techniques of measurement are not yet available.

2. The method I describe documents areas in which a physician's diagnostic profile deviates from his peer group. Specific indicator conditions that meet the criteria described by the National Academy of Sciences publication on evaluating health services may be selected from within the deviant areas.

3. The National Health Examination Surveys give considerable information about some disease states but do not give data on how interventions affect outcomes. These data can only be derived from careful, prospective, clinical trials.

4. Physicians' practices may be biased, but bias is less likely for family physicians than for other specialists. Our method which includes an age-sex register can uncover some areas of bias.

5. My article concerns evaluation of "process." It is one of several possible techniques and by no means the only one. Assessment of quality of care by outcome measures is difficult but perhaps not impossible. If Dr. Buttery wishes to pursue this line of research he is, of course, most welcome to do so and I wish him luck.

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