

Human Relations Training for Family Practice Residents: A Four Year Retrospective Review

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The Family Practice Center of Akron has developed and implemented a human relations training program as an integral part of the family practice residency curriculum. Following two years of planning and experimenting, a 12-month course of study was formalized in July 1975. Two full-time behavioral scientists are responsible for planning, coordinating, and teaching the curriculum. The curriculum includes a variety of learning experiences throughout the three years and represents approximately ten percent of educational programming and costs.

Since human behavior is a divergent yet encompassing concept, physicians will need to become students of human behavior to effect change. Behavioral science concepts and applications will prove to be viable contributions to residency training if this education (1) facilitates skill development and (2) produces visible results relative to the variety of interpersonal encounters of a family physician. The challenge facing behavioral science educators is to develop a curriculum of study that will motivate family practice residents to develop and use behavioral skills as an integral part of family medicine.

The major premise of this paper is: behavioral science education can be integrated into a family practice residency curriculum throughout three years. I intend to address several critical questions which family medicine educators, physicians, and behavioral scientists must be prepared to answer.

What is a behavioral science curriculum? How do you implement such a program in a 12-month, three-year time frame? How much does a program cost? Who should be the faculty and what will they do? How do you evaluate program and learner effectiveness? The *purpose* of this paper is to share the experiences of a community hospital's family practice residency which was confronted with limited finances, administrative and attending staff "stand-offishness," resident skepticism, and faculty naiveté.

Background

Dr. Gayle Stephens has suggested that behavioral science can contribute to clinical practice in seven major areas.¹ (1) There should be an emphasis on the *interactional* nature of clinical practice; that is, the role theory as it applies to the doctor/patient relationship. (2) *Models for understanding human development* should be presented in a clear and concise manner. (3) The *dynamics of groups* and group

process are important learning concepts. (4) Residents need a basic understanding of *cultural variables*, and also of how people live in their aging years. (5) *Models of therapy* covering both traditional and contemporary approaches will expand human relations skills. (6) There is valuable input to be gained from *organizational theory*, administrative sciences, industrial psychology, and office management systems. (7) *Formal methods of research* and analysis should be integrated into the learning experiences.

During the past four years, the Family Practice Center of Akron has been mindful of these suggestions. A three-year curriculum of study has been implemented to develop family practice residents' interpersonal skills and competence in recognizing and dealing with behavioral dimensions of disease.

Balint Groups

On the basis of his studies of psychological implications in *general* medical practice, Dr. Michael **Balint** found that "by far the most frequently used drug in general medical practice was the doctor himself/herself."^{2,3} Balint went on to formulate three secondary conclusions regarding the behavioral implications of the doctor/patient encounter. First, no pharmacology of this important drug exists. Second, no guidance is contained in any textbook as to dosage. Third, there is a lack of *literature* on the possible hazards of **this medication**

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or its undesirable side effects.

Balint further concluded that in spite of our almost pathetic lack of knowledge about the dynamisms and possible consequences of "reassurance" and "advice," perhaps these two are the most often used forms in which the "drug doctor" is administered. The emergence of this information and the interest of general practitioners in participating in a human relations training experiment were stimuli for Balint's formal training groups, which set out to study the doctor's role and develop understanding of the doctor/patient relationship.

Balint's concept of the "drug doctor" and his training approaches were

motivating factors for the development of a relevant learning experience for Akron City Hospital family practice residents. We had in mind much the same goal as Balint's training program and were equally inexperienced in determining the "what" and "how" of behavioral training.

Early Developments

Initially, the residency faculty were uncertain of the content and methods necessary for an effective behavioral science program. Behavioral strategies,

counseling methods, psychological theories, learning theory, and audio/video taping were all thought to be important. However, there were very few models to emulate. Therefore, the task was to draw from and adapt both traditional behavioral science concepts and contemporary human relations training.

The early planning sessions focused upon behavioral models relative to doctor/patient encounters. The intention was to enhance residents' interviewing skills and their recognition and treatment of behavioral problems. The curriculum was, first of all, influenced by the following concepts: Transactional Analysis, Reality Therapy, Maslow's Theory on Motivation, Family Therapy, and several leadership and managerial development models.

Audio/video taping was considered a primary tool for developing interviewing skills. This method was considered a new and innovative concept by medical educators and almost "unheard of" by residents.

Resident skepticism and resistance were evident because of several questions in their minds. *What can a non-physician teach me? Is this sensitivity training? Are they going to tell me to do things I don't want to do? How will I look on video tape and what will they do after the taping?* These issues evoked intense feelings and each question was candidly discussed by faculty and residents.

Several positive developments occurred from the early experiences. Each faculty member was involved in the planning before programs were implemented. The first attempt at formal conferences, workshops, and audio/video review sessions were experimental, and follow-up programs were scheduled only after resident feedback and faculty evaluations. Residents provided input into the format and content of the programs. Negative reactions and dissatisfactions were dealt with as quickly as they surfaced.

There are several aspects of our early work which I offer as cautions. The conferences were too didactic and did not focus on applications of behavioral science. Many of the consultants had very little experience with resident physicians and they did not address the concerns of "how to deal with the problems." Audio/video equipment was introduced without an understanding of its educational value.

Table 1. Behavioral Science Conference Topics*

Family Health	Behavioral Science/ Practice Management	Human Relations Seminars
Pregnancy	Behavioral science objectives	Child rearing
Childbirth/post partum	Theories of health and growth	Ethnic differences
Infant and the family	Applications of TA	Parental nurturance
Child neglect/abuse	Behavioral strategies	Sex-linked roles
Premarital visit	Depression	Freud's phases of psychosexual development
Working mothers	Anxiety reactions	Sullivan and Erickson
Enuresis	Crisis intervention	Piaget's approach to cognitive development
Unwanted pregnancy	Reality therapy	Jung
Family interviewing	Leadership styles	School phobia
Human sexuality	Group process	Child abuse
Divorce and remarriage	Motivation and job enrichment	Empty nest syndrome
Middle years and beyond	Office accounting practices	Family crisis
Death, a life experience	Medical/legal issues	Female alcoholic
	Insurance and estate planning	Lonely elderly
	Financial planning	Adolescent female
	Family and children's services	Adolescent male
	Child guidance center	Encopretic child
	Welfare and public assistance	Physically handicapped
		Adoption
		MD support systems
		Single parent

*Additional conference topics are selected and presented by family practice residents.

Table 2. Audio/Video Review Form

Resident _____

Reviewer _____

Situation reviewed _____

Date _____

Key
 S = strong
 W = weak
 √ = no opinion or insufficient data

Interview Structure

- _____ Opening
 - _____ Identified plan — physician's agenda
 - _____ Administration/amount of time
 - _____ Sets expectation

- _____ Structure of questioning (general/specific)
 - _____ Rate/pace
 - _____ Flow/exchange
 - _____ Non-biased questions
 - _____ Clarity

- _____ Maintenance of control
 - _____ Use of time
 - _____ Actively takes charge
 - _____ Tells patient what physician is looking for

- _____ Integrations
 - _____ Systematic plan
 - _____ Transitions

- _____ Termination
 - _____ Summary
 - _____ Patient and physician agree to closing

Comments

Interview Process

- _____ Establishment of rapport

- _____ Listening behavior
 - _____ Eye contact
 - _____ Seating arrangement of furniture
 - _____ Use of chart
 - _____ Awareness of verbal and non-verbal clues
 - _____ Body posture
 - _____ Verbal reinforcers

- _____ Demeanor
 - _____ Status-role relationships of physician and patient
 - _____ Naturalness
 - _____ Sensitivity
 - _____ Positive and nonjudgmental attitude
 - _____ Recognizes patient's feelings
 - _____ Recognizes one's own feelings

- _____ Supportive behavior
 - _____ Positive tone of voice
 - _____ Use of touch
 - _____ Appropriate use of reassurance
 - _____ Shares feelings when appropriate
 - _____ Uses silences and pauses
 - _____ Focuses on the here and now
 - _____ Uses confrontation

Comments

Program objectives, performance standards, and faculty responsibilities were vague and many of the educational approaches were often seen as "gimmicks." Family practice attending staff were uninformed about residency programming and their clinical expertise and maturity were often underutilized.

Following nearly two years of planning and testing, a formal behavioral science curriculum was initiated. This curriculum contains objectives, program schedules, faculty responsibilities, an outline of content knowledge, evaluation measures, and a bibliography of resource material. The following paragraphs summarize the behavioral science curriculum of Akron City Hospital's family practice residency.

Curriculum Objectives

A logical progression for behavioral training would be *first* to prepare a family physician to become keenly aware of personal feelings and understand his/her reactions to people and their problems, and *second* to use this insight to focus upon the responsibility of the physician to perform in a nonjudgmental manner. The minimum implied contract, from the physician's point of view, is that he or she will receive and accept a person with as little prejudice as possible and will mobilize available resources, human and material, to deal with the person and problem.¹

Three criteria to consider in preparing behavioral objectives are: (1) describe the learner's behavior or performance, not the method of teaching, (2) relate the performance to an end point rather than the means, and (3) describe terminal behavior and level of performance which will be considered acceptable.⁴

There are five performance features of skill development which may cement learning experiences. These include *discrimination* — knowing when to do it, *problem solving* — how to make decisions, *recall* — knowing what to do, *manipulation* — how to do

it, and *communication* — verbally expressing ideas and expectations.⁵

The family physician who recognizes a need to understand human behavior and develop appropriate skills will be looking for two things from behavioral science: *theoretical frameworks* in order to organize observations and *practical aids* for management of patient's complaints. Behavioral science education should equip the family physician to understand and develop an analytical framework regarding behavior in interpersonal relationships, behavior in the family, and behavior between doctor and patient.⁶

Examples of behavioral training objectives⁷ for family physicians in the form of knowledge, skills, and attitudes are:

Knowledge objective: *The resident shall demonstrate a working knowledge of the impact of such behavioral problems on individuals and families as depression, sexual dysfunction, alcohol and drug abuse.*

Skill objective: *The resident shall demonstrate supportive and empathetic behavior in the face of death and dying during individual and family crisis situations.*

Attitudinal objective: *The resident shall exhibit an awareness of practice management principles and an interest in their applications for eventual practice.*

The following educational methods were designed to facilitate family physicians' learning in both conceptual models and practical management tools.

Educational Methods

Human relations should be an active process with the residents' learning evolving from interpersonal encounters.⁸ Since the core issue of family medicine is "the person," an effective behavioral science program must integrate personality theories and human behavior concepts into a three-year learning experience.

Miles⁹ presents eight conditions

which may generate an active learning atmosphere. (1) The learner must see the importance of "unfreezing" usual ways of behaving, including perceptions and feelings, cognitions and values, as well as overt action patterns. (2) Teacher and learner need to identify new actions and determine "what is the appropriate way to act?" (3) Opportunities must exist to engage in new action under a threat-reductive atmosphere. (4) Consequences of the action must be recognized as having a positive instrumental value. (5) New behavior must be recognized as having positive value. (6) Real results and desirable rewards must be evident. (7) The learner must be able to relate the action-consequence pattern to problems faced in reality. (8) The learner must leave the training experience motivated with a clear sense of "things to do."

The primary methods of instruction at the Family Practice Center of Akron, which integrate Stephens' suggested content areas and Miles' action learning conditions, are weekly conferences, audio/video reviews, and semiannual workshops. These three methods are summarized in terms of their features, functions, and benefits.

Weekly Conferences

There are three regularly scheduled behavioral science conferences in each academic year. There is a weekly behavioral science/practice management seminar, a biweekly family health conference, and a weekly human relations seminar. These conferences are held at noon on Tuesday, Monday, and Friday respectively. Senior residents are the principle attendants on Mondays and Tuesdays, while first and second-year residents alternate in the Friday sessions. The *features* of these conferences are as follows. Each session is approximately 1½ hours long. Presentations are given by faculty, consultants, and residents. There is a 12-month schedule of topics and speakers. The *functions* of these ongoing programs are as follows. They provide a forum for discussion between faculty and residents with a

continuity of subject matter. In addition, there is constant flow of information on the recognition and treatment of behavioral dilemmas and problems. The *benefits* of these small group meetings include the following. Behavioral science is seen as an ever-present element of the curriculum. There are opportunities for periodic assessment of residents' knowledge and skill development. The Family Practice Center conference program has proven to be a source of practical ideas for patient and family care.

Table 1 presents a list of topics for each of the three conference programs.

Audio/Video Taping and Reviews

A second method of instruction is the audio/video taping of residents in individual and family encounters and the playback and review of these encounters. Table 2 presents the form used to provide residents' feedback after their review sessions. A copy is given to the resident immediately after the session and one copy is kept in his/her performance file. There are several *features* which constitute the audio/video review program. Each resident is taped and reviewed monthly. Physician and behavioral science faculty conduct individual and joint review sessions. Reviews are scheduled from 1½ to 2 hours in length. Tappings are made of patient, family, and nurse encounters. The educational *functions* of audio/video reviews are as follows: residents may pre-select patients or tape patients on a random basis. Both patient and resident behaviors can be observed in the context of the "real encounter." Learning is focused upon descriptive critiques such as non-verbal communication, family dynamics, and the elements of effective interviewing. There are several *benefits* which have resulted from the audio/video review sessions. The reviews provide opportunities to observe both the medical and behavioral features of the doctor/patient encounter. Patients and their problems may be observed over a period of time to assess residents' skills and progress in a variety of situations. Management of time and utilization of paramedical staff are made possible by taping the hallway activity and doctor/nurse interaction.

The audio/video-taped encounter is a valuable tool for studying patient behaviors and assessing the "actual

reason for coming." The reviews of taped patient encounters require supervision and instruction outside the realm of subjective judgments and conjecture. While this educational tool is highly personal, it does enable the educator and resident to analyze the transaction from three possible viewpoints: no illness situation, unorganized illness, or organized illness.¹⁰

Workshops

Extended training sessions away from the learner's daily work environment are common in professional educational programs. The "content" and "process" of human relations development may be enhanced with a comfortable learning atmosphere. The Family Practice Center of Akron has conducted seven two-day workshops since August 1973. The *features* of the behavioral science workshop are as follows. There is a fall and a spring program, with spouses invited for the fall program. Ample recreation time is provided during the two-day session. Behavioral science consultants are utilized as resource persons. Residents provide input in both planning and implementation stages. There are several significant *functions* of these training programs. They enable residents and faculty to spend an extended amount of time together in an informal yet educational setting where residents and faculty take part equally as learners. Behavioral problems and strategies can be dealt with in more detail than during a noon conference. Consultants develop more appreciation of family medicine educational needs. The *benefits* which have accrued from these workshops include the following. A feeling of group process and trust has developed. Behavioral science is recognized as an integral element of residency training. Experiential learning is seen as a valuable method of skill development. Schedule conflicts are minimized and few distractions have occurred. During the spouse-attended workshop, the entire "family" of residents and faculty acquire a sense of identity and purpose.

The workshop format and "retreat" atmosphere may be threatening to residents, spouses, and faculty, especially if there are serious problems in a personal or professional relationship. The use of this educational

Table 3
Behavioral Science Introductory Course
(28 hours)

Course topics (each session is 3½ hours)

1. Communication and motivation concepts, effective listening, interviewing methods
2. Gestalt exercises: group process and compliant behavior
3. Transactional analysis: ego states, games, role plays, audio/video reviews
4. Dynamics of family functioning: family as a unit, stress reactions, video-tape program
5. Transactional analysis: structuring time, intimacy, contracting, role plays
6. Affective and task related communication: group exercise
7. Leadership and group dynamics: self-assessment and group exercise, audio/video critiques
8. Modes of behavioral control: rigid, flexible, laissez-faire, chaotic, video-tape exercise

method should be planned thoroughly, and structured so that maximum benefits will be derived. The residency faculty and consultants should have experience with this method prior to its use.

Other Educational Programs

Additional educational experiences in behavioral science include: a 28-hour introductory course during the first month of the residency for first-year residents (Table 3) and an extensive practice management and leadership development program.¹¹

Table 4 presents an approximation of the hours residents spend in each educational method.

A few precautionary comments to educators are to be aware of "educational overkill" or, stated more precisely, letting the mechanics of education interfere with learning and skill development. The following should be red flags for educators: extensive didactic and esoteric conferences with

**Table 4. Behavioral Science Input Per Resident for Three Years
(2 full-time faculty, and part-time consultants)**

	First-Year Hours	Second-Year Hours	Third-Year Hours	Total Hours
Weekly conferences/seminars	60*	60	80	200
Workshops (semi-annual)	30	30	30	90
Audio/video reviews	20	40	60	120
Resident projects and presentations	—	10	30	40
Practice management and leadership development	—	30	100	130
Total Hours	110	170	300	580

*Includes 28-hour introductory course in July

rigid programming, critique sessions with heavy evaluative remarks, socialization and/or fraternization between educators and learners, selling behavioral theories as solutions, continuation of block instruction, and presuming faculty have mastered teaching skills as a result of practice experience or years in academia. In addition, one should avoid short-cutting planning, not communicating expectations, and projecting unrealistic results regarding new developments such as computers, audio/video equipment, additional faculty members, and other dynamic effects on the educational programs.

Faculty

A full-time behavioral science faculty should be considered, especially if there are senior residents. The Family Practice Center of Akron has two full-time behavioral scientists. Backgrounds from which to consider prospective faculty include clinical or educational psychology, psychiatric social

work, clinical pastoral counseling, family therapy, and professional management training. The academic credentials or clinical experience may *not* be as important as the compatibility of the individual(s) with the educational goals, methods, and environment.

Behavioral science staff should possess knowledge and skills in several of the following areas: curriculum planning, performance appraisal and evaluation, individual and group process teaching, audio/video instruction, counseling and interviewing, research and report writing, behavioral science theory and concepts, and social and community resources.

The full-time faculty should select appropriate resources to complement personal expertise and interests. Specialized psychological, social, and economic resources will be valuable to both educational and patient care functions. The Family Practice Center of Akron has used a group of clinical and educational psychologists for psychological referrals and educational programs as well as two educational psychologists outside of Akron who have made significant contributions to the behavioral science curriculum through their consultations.

Faculty Development

Family practice faculty will face a variety of learning situations and problems. It is unlikely that educators, behavioral scientists and physicians, will be completely prepared for their tasks. Educators need to acquire knowledge and skills in group leadership, where the emphasis is upon group development and not leadership domination. Behavioral scientists must appreciate the impact of their subject upon the learner and be sensitive to residents' anxieties, concerns, and resistance to change.¹²

Developing and refining instructional skills should be of prime concern in family medicine education. Faculty development should be a commitment by all educators and especially those of us in a dynamic and ever-growing academic endeavor.

Educational Costs

Behavioral science expenses have represented slightly less than ten percent of the total residency budget, the two major expenditures in the behavioral science budget being faculty salaries and audio/video equipment. Table 5 presents the costs during the first years of development, excluding faculty salaries.

Federal grants subsidized \$16,000 of the \$20,000 audio/video equipment cost. Initial funding for behavioral science faculty was also secured from HEW grants. However, the federal revenue source is now depleted and most of the financial burden for educational costs is assumed by the hospital.

During the academic year 1975 to 1976, a \$4,500 expenditure was allocated for an evaluation of the behavioral science curriculum. A group of clinical/educational psychologists was contracted. The next section presents the format of that study.

Curriculum Evaluation

Family medicine educators and

Table 5. Behavioral Science Expenditures

Audio/Video Equipment

Cameras: 6 fixed position, including 3 with pan/tilt zoom lens
1 portable with tripod

Total 7 cameras

Recorders: 1 3/4" cassette
1 1/2" reel-to-reel

Total 2 recorders

Monitors: 1 special effects monitoring console
1 21" mounted in conference room
1 18" portable unit

Total 3 monitors

Microphones: 7

Total Cost Including Installation (1974-1975 prices): \$20,000

Yearly Expenses (excluding salaries and fringe benefits)

Faculty travel (two meetings/person) \$ 2,000

Two workshops attended by faculty, residents, spouses 1,500

Consultants (30 hours/year) 1,500

Educational materials and supplies 1,000

Audio/video maintenance costs 500

Total Expenses \$ 6,500

clinicians are becoming more clearly aware of the need for effective human relations skills in the delivery of health-care services. If more care, concern, respect, and understanding are communicated among health-care professionals, less anxiety and frustration will arise.¹³ The task before behavioral science educators is not only to develop systematic training but also to evaluate the effects of this upon the resident physician. There are several critical areas to assess in a behavioral science curriculum including: (1) relevance of content material, (2) quality of instruction, and (3) the progress of the learner's skill development.

The Family Practice Center of Akron has formally evaluated the behavioral science program in two ways: first, through contracting an educational psychologist to participate in and assess the different methods of instruction and faculty performance

for 1½ years, and second, by conducting a pilot research study with incoming residents regarding the development of interpersonal skills.

Educational Consultant

An educational and clinical psychologist was asked to review the program and make a consultation report. This report was presented following 1½ years of the consultant's participation in various aspects of the behavioral science curriculum, including conferences, workshops, audio/video reviews, and planning sessions with faculty. The consultant's evaluative remarks were very favorable. He observed three major factors at the Family Practice Center of Akron: (1) behavioral science concepts are tailored to the needs of family practice physicians, (2) the curriculum offers relevant content through a variety of

learning and teaching formats, and (3) residents are provided opportunities to increase knowledge and skills beyond the classroom and laboratory settings. The consultant further reported that there were several related factors which have influenced the quality of the behavioral science curriculum: (1) existence of trust, rapport, and communication, so that all faculty and residents feel a part of the policy making; (2) sense of group identity and cohesiveness around common goals and results; and (3) selection process of residents which is based on individual qualities and capabilities and not similarity to faculty.

Pilot Research

A pilot research study was undertaken in July 1975. Western Reserve Psychological Associates, a group of clinical and educational psychologists, was contracted to ascertain the importance of behavioral science relative to the residents' development of interpersonal skills. They chose to study the incoming group of residents and a control group of non-family-practice residents for one year. The evaluation focused upon three areas: first, the value system of the new residents; second, the patients' response to residents immediately after the visit to the office; and third, physician/patient interaction in the examination room. There were five tests administered during the evaluation. These were:

*Allport, Vernon, Lindzey Study of Values.*¹⁴ These values are (1) theoretical, (2) economic, (3) aesthetic, (4) social, (5) political, and (6) religious.

*Gordon Survey of Interpersonal Values.*¹⁵ The scales are (1) support, (2) conformity, (3) recognition, (4) independence, (5) benevolence, and (6) leadership.

The Semantic Differential (Osgood 1952).¹⁶ This scale is designed to evaluate the feeling of favorableness (attitude) towards an object or person. A 15-item scale will be developed for patients to rate their feelings toward the resident.

The Affect Sensitivity Scale (Kagan 1967).^{17,18} This scale will be utilized to measure levels of empathetic perception. The stimulus is a film of 34 scenes selected from counseling sessions.

The Counselor Verbal-Response Scale (Kagan).¹⁹ This scale attempts to measure those characteristics of verbal behavior which reflect effective counseling procedure. To use the scale, a doctor/patient interaction will be recorded on videotape and then rated by specially trained judges.

The major portion of the \$4,500 allocated in 1975 to 1976 for evaluation was spent on consultants' time for administering and scoring the five performance and attitude measures. There was pre and post-testing in July 1975 and June 1976 respectively, using Kagan's Affect Sensitivity Vignettes, the Allport, Vernon Study of Values, and the Gordon Survey of Values. Each resident was video-taped during two patient encounters in the months of August 1975 and May 1976 to assess interviewing techniques and to assess interviewing techniques and doctor-patient interaction. It was hoped that this evaluation could continue for at least three years, but funding was not available and the evaluation was concluded as of June 1976. The results of this study will be reported at a later date when data are tabulated and analyzed.

In the training of counselors, Truax and Carkhuff²³ found that the core conditions in a helping relationship were empathy, respect, warmth, concreteness, genuineness, confrontation, and immediacy of relationship. They believed these ingredients are essential learning skills in a human relations training model. Several studies have attempted to study the impact of the doctor-patient relationship and assess the need for interpersonal skill development by physicians. Ley and Spelman²⁴ asked physicians to make a special effort to inform patients about their illnesses. In spite of physicians' willful intention to be helpful, patients voiced dissatisfaction over one third of the time. Bates²⁵ concluded that once trust and affection develop a number of results occur: (1) satisfied patients follow their physician's directions; (2) patients speak highly of their physician and make recommendations to friends; (3) they pay their bills promptly; and (4) they demonstrate confidence in their physician's competence. Shocket²⁶ discussed the difficult patient in the general hospital. He emphasized that "quality of patient care is more likely to deteriorate if there are difficulties in the area of doctor/patient communication."

Additional research support for the use of systematic human relations training may be found in a variety of sources. Some of these are Carkhuff and Truax,²⁷ Vitalo,²⁸ Carkhuff,^{29,30} and Seidenschur.³¹

Discussion

The need for training in human relations skills has been described by expert observers within various health-care specialties and has been documented by research. The technology for delivering the training has been developed by psychologists and other behavioral scientists. Three authors who have completed recent publications relative to this topic are Carkhuff,²⁰ Gazda,²¹ and Egan.²² Their writings would be valuable reference material for both educators and learners.

Although there have been comparatively few research studies in which a systematic human relations training approach was applied to physicians and other health-care practitioners, there are numerous studies in related fields which demonstrate the value of behavioral science education.

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