Behavioral Science in Family Practice: An Ethical Imperative

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Behavioral science confronts at least three major problems within American medicine that must be overcome if the family physician of the future is to receive an adequate graduate education and maintain his professional integrity. Through increasing specialization, the once unified biological perspective of man was severely fragmented, and with increasing emphasis on the science of medicine, the disease process was objectified and reified. Twentieth century man joined his myth of technological mastery with medicine's desire to eliminate pain and suffering. This gave rise to the idea that life could be medically managed and existential dilemmas anesthetized. To overcome these problems behavioral science has two ethical issues to address in family medicine. First, behavioral science must restore the physician's sense of personhood by recognizing the person of the physician as the primary diagnostic and therapeutic "tool" of family practice. Second, behavioral science must help family practice refocus its professional responsibility on the social problems of the day. This will happen through a critical review of the custodial aspects of the physician's role and an emphasis on role innovation. Approaches to these two ethical issues at the Medical University of South Carolina family practice residency are described.

In a preceding issue of *The Journal of Family Practice* a paper appeared entitled, "Developing Behavioral Science for a Family Practice Residency," written by the Division of Behavioral Science at the Medical University of South Carolina, Charleston.[1] That paper dealt with many of the theoretical problems of formulating behavioral science goals and objectives, and the practical problems of implementing those objectives. Consequently, this article will address the ethical imperatives that require the incorporation of behavioral science into family practice. An attempt will be made to spell out what some of the special attributes of such a behavioral science program should be, if family medicine is to maintain its professional integrity and discharge its responsibility both to society and to the future generation of family physicians. It is this writer's thesis that a profession requires not only technical competence and theoretical mastery, but also ethical standards against which its individual members can judge their practice and against which the profession collectively is held socially and politically accountable.

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Some Problems Facing Family Practice

The first problem that family practice faces involves the fragmentation of its once unified biological view of man. Physician and philosopher Karl Jaspers, in his 1963 English edition of the essay "The Ideal of the Physician," articulated clearly the problem that family practice is currently addressing in the wake of overspecialization. Jaspers said,

> Increasing skill tends to confine the specialist to special ways of thinking. A patient is subjected to a long series of specialized methods of examination and treatment; yet these will thwart their own meaning if they are not guided by the vision of a doctor who keeps the entire person and its real situation in view.
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> Today we still have instances of a true and splendid biological point of view, but the general trend seems to be in the other direction. All over the world we train people who know a lot, who have mastered particular skills, but who fall short in independent judgment and in the power to explore and fathom their patients.
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> These trends of specialization and overinstruction are universal trends of our time. The technology of mass production and the association with human masses lead everywhere to a leveling that reduces men to mere parts of a machine. The power of judgment, the faculty of broad observation, personal spontaneity – these are paralyzed by mechanization.
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> Besides, the relationship of doctor and patient itself becomes involved in mass organization. The unavoidable public health insurance and the enormous size of our hospitals jeopardize the original relations of the individual doctor with the individual patient.[2]

A second problem is the threat to the original, individual relation of doctor and patient. This problem was more recently outlined by Murray Wexler in his paper, "The Behavioral Sciences in Medical Education, a View from Psychology," that appeared in

the April 1976 issue of the *American Psychologist*. In Wexler's words:

Since the end of World War II, some segments of the medical community, abetted by the increasingly influential sciences of human behavior, vigorously inveighed against what they consider to be the rapid decline in the human side of medicine. The complaint, briefly stated, was that the technical revolution had created an array of tools with which to do things *to* people, thus resulting in less and less time to do things *with* people. The atmosphere was becoming increasingly impersonal, and the physician was placing the person in the role of "patient as object." . . . the tendency [was] to separate the disease from the individual experiencing it. This segregated view, self versus body, became something of a battleground for medical educators during the last 25 years. The new view one heard expressed with increasing frequency might be summed up in the slogan, "patient as person." This concept has been moving into the ascendency in recent years, perhaps best reflected in attempts to develop patient-centered (or more properly, person-centered) curricula with the object of reuniting technical medicine with human medicine.[3]

To further characterize and, if you will, dramatize the problem confronting behavioral science and family medicine in 1976 we must give serious attention to the radical prophet-priest, Ivan Illich. His interpretation of a third major problem facing family practice is that medicine has imposed on human life a pseudoscientific myth which allows the doctor to manipulate and manage the person. Thus, the individual is denied the existential struggle through which his growth, development, and suffering can acquire personal meaning. Following is only the briefest outline of his thinking. These words are taken from his interview with Sam Keen, in the May 1976 issue of *Psychology Today*.

Almost all aspects of life – pregnancy, birth, puberty, old age, and death – have now been turned into problems that medical professionals are expected to treat.

When you have medicalized birth, hospitalized disease, and institutionalized death, you have, as Roslyn Lindheim says, "hospitalized the city." The hospital is the modern cathedral and the physician is the priest who officiates over our rites of passage from one stage of life to another. He turns sucklings into babies, puberty into a critical stage, adulthood into a constant multiple patienthood always dependent on specialties, and he turns the old into the aged.

We prefer to label people sick rather than criminal or politically deviant, or as lazy. And we use the idea of sickness to excuse us from taking social and political responsibility for our condition. So of course we expect physicians to produce miracle cures and to save us from disease and death.

The doctor becomes the patient's accomplice in creating the myth that he is an innocent victim of biological mechanisms.

The modern medical enterprise is organized to kill pain, eliminate sickness, and abolish the need for an art of suffering and dying. Pain is now detached from any context that could give it meaning and is turned into a technical problem that has to be solved by the physician.

The physician is trained to focus only on that aspect of pain that is accessible to management by an outsider. The questions that are as integral to physical pain as the loneliness of suffering – What is wrong? Why me? Why does this evil exist? What should I do? Can I bear it? – are anesthetized. And the patient is trained to perceive his own pain as a clinically objective condition that can be managed by a scientific professional.

And now the ultimate intransitive activity – dying – is managed by professionals and consumed by clients. Death that once was viewed as a call from God and later as a natural event has become an ultimate event that is the outcome of our technical failure to treat a disease.

You ask what I mean by cultural iatrogenesis. I mean the destruction, by a standardized white-coat policy of crisis management, of the hundred ways in which the individual might accomplish in a solemn manner that last expression of health that consists of living it up to the last moment.[4]

Through the words of Jaspers, Wexler, and Illich, I have tried to characterize the major problems that behavioral science and family medicine must confront in their teaching programs. Whether university oriented or community based, the cathedral-hospital has been, throughout medical school and on into residency, the primary learning center for the family physician. There he or she has learned from a diversity of priestly specialists how to identify disease processes and how to coordinate the technology of medical science and the mass production processes of the hospital in controlling disease. For large portions of his family practice residency, the resident is expected to continue to officiate at medical rites that further imprint on the patient the "cultural iatrogenesis" that may erode his or her existential integrity and the cohesion of his or her family. How then is the young doctor to be free to mature as a family physician? Just what ethical responsibility does behavioral science bear for seeing to completion such an undertaking?

Ethical Imperatives and Teaching Approaches

In thinking about what part behavioral science should and must play in the education of the family physician our attention must first fall on the person of the young doctor. Wexler pointed to the humanizing move in medical education captured in the slogan, "patient as person." I want to suggest not another slogan, but rather, the first ethical imperative for behavioral science in family practice: *behavioral science teaching must address the physician as a person.* Teaching which merely tends to broaden or refine patient management skills by adding new clinical techniques derived from psychology, sociology, or anthropology must assume second importance in the curriculum to the physician's reflection on their place in his or her life. In other words, the person of a physician is the primary diagnostic and therapeutic "tool" of family medicine. The family physician must not be reduced to a technical extension of medical science, and medical protocol must not displace dialogue between the physician and the patient.

The physician must existentially confront his loneliness and suffering, his strained family loyalties, the evil of which he is a part, and his ultimate human frailty and demise. His or her educational goal is not simply to learn the normal or characteristic stages of the life process and how to anesthetize the patient from their effects. This would be simply an extension into the residency of already unnecessarily protracted technical training. To my thinking, the words of Jean Jacques Rousseau most clearly differentiate technical training and education of the kind essential for the physician. In Rousseau's words: "He among us who can best carry the joys and sorrow of life in my opinion is the best edu-

cated."

To facilitate the cultivation of the person of the young physician, we in Charleston have incorporated into the behavioral science curriculum the following programs. Early in the orientation program for all first-year residents, a series of psychological tests is given. The psychological tests were not chosen to allow the staff to isolate or identify pathological symptoms or traits. The tests were chosen as one of the ways in which the residents might become more objectively conscious of their values, personal needs, and inner personal style, whether relating to other individuals or to groups. All the data gathered on these psychological tests are returned to the residents. At that time, the test variables are defined to the resident. The norms (means and standard deviations) describing the residents' performance as a group are presented. This allows each resident within the class to see where he stands, first, in relation to his own perception of himself, and next, in relation to his peers. In addition, the resident is also given the test norms of the preceding classes in the residency program. There is no attempt made at any time to synthesize the data into a critical appraisal or profile of each resident. Rather, the test scores are used by the resident as one kind of mirror to his behavior. If he desires, he is free at any time to sit down with a personal counselor of the behavioral science faculty and review in greater detail what the test scores say about him, and what additional inferences may be drawn from them. Following the return to the residents of their scores and the norms of their particular residency class, time is provided to allow the residents in groups of two or three to discuss with each other what their test scores mean to them, and what validity colleagues see in the scores they have received.

For the family physician to grow as a person, a time and a place must be set aside, in an otherwise totally other-directed environment, to allow the resident (and his spouse, if he or she so desires) to see himself: where he has come from, where he is, and where he is going. Thus, a self-appraisal program was created. Each resident selects, in his second and third year, a behavioral science faculty member as a personal counselor. Each year he sees a different faculty member for a one-hour session twice a week during a specified two-month period. He may schedule additional time through the year as desired. The resident is free to terminate the appraisal experience at any time after a thorough discussion with the counselor as to his reasons for doing so. The first-year resident is also asked to select a personal counselor by the end of the two-month orientation program. This personal counselor will contact the resident monthly during the first year to schedule appointments for counseling. Here again, additional appointments may be made if desired. The focus of this program is to be a personal one, ie, the resident is given an opportunity to examine how he feels about his life, including his profession. No formal records are kept of what transpires in a session so as to maintain a high degree of confidentiality.

The purposes of such an endeavor are as follows:

1. To enhance the family doctor's professional and personal relation with his patient.

2. To increase the probability of his or her living an emotionally satisfying and complete life, ie, to facilitate his/her self-actualization.

3. To establish early the habit of seeking help and sharing one's personal problems, frustrations, delights, and ambitions.

A two-day basic encounter group during the first-year orientation program also allows the residents the opportunity to give and to receive direct feedback from peers and faculty. This behavior is normed not only in the encounter group, but also throughout the residency. The encounter group also provides an opportunity for the resident to learn firsthand the interdependent or social aspect of his existence and the far-reaching implications it has for the delivery of health care. Hopefully, the resident's training in encounter groups and other health team meetings allows him/her an opportunity with his colleagues to see how groups handle business, how they establish membership, what they have decided upon formally or informally as a way of making decisions and what values seem to be underlying the choice of problems and their corresponding solutions. It is upon the basis of understanding both personally and objectively one's membership in a group that the doctor begins to appreciate the underlying dynamics of the doctor-patient relationship and the patient's relationship within a family or work setting.

Richard Beckhard, organizational consultant and senior lecturer at the Sloan School of Management, Massachusetts Institute of Technology, in a speech delivered to the Congress of Medical Education in Chicago in 1974, made the following observation,

> Care given to patients is increasingly given in a family environment. The delivery team is in a real sense a family. It has all the usual problems, parental authority, sibling rivalry, differential learning styles, different career priorities. If a delivery team can look at its own life as analogue to the patient family, there are a number of corollary benefits or extra bonuses for all the learners.[5]

In addition to these formal programs, behavioral science faculty while attending in the clinic are as attentive to the resident's personal response to the patient as to the quality of health care the patient is receiving. Much more could be said about the formal and informal attributes of a behavioral science program that encourage the cultivation of the person of a family physician. However, I feel it is important to move on to postulating the second ethical principle that should direct the teaching of behavioral science in family practice.

Behavioral science teaching and the behavioral science curriculum must promote role innovation. Edgar H. Schein in his paper, "Occupational Socialization in the Professions: The Case of Role Innovation," clearly spells out the implications of role innovation.

> The essence of role innovation is a basic rejection of the norms which govern the *practice* of the profession combined with a concern for the role of the professional in society. The role innovator redefines: (a) who is a legitimate client; (b) who can or should initiate the contact between client and practitioner; (c) what is an appropriate setting for conducting professional practice; and (d) what are the legitimate boundaries of the professional's area of expertise. Underlying each of these is a concern with making the profession more relevant to the pressing problems of society.[6]

Behavioral science in family practice should broaden the traditional definition of "legitimate client" to include "the person in his social setting," the family, and it should train

the resident how to understand family and social processes and their dis-ease. "Contact" made by any person in the family should automatically alert the family physician to the other members in that family constellation and should also prompt questions concerning outlying social systems such as the school, dormitory, factory, or office. The "appropriate setting for conducting professional practice" should be shifted from an office visitation room or the hospital exclusively, to include the social setting (home, apartment, etc) where the physician, or one of the primary health-care team, may meet and interview or "treat" the person.

The "legitimate boundaries of the professional's area of expertise" should be extended to include a knowledge of the psychological, social, and cultural aspects of the patient and the doctor. In other words, the patient should be removed from the restricted category of disease-carrying organism and the physician should be removed from the confining category of a medical scientist who must, on occasion, listen to patients to gather diagnostic data. Each should now be seen as a person who functions within a social system and is responsive to, and responsible for, the press of his cultural environment. Direct treatment of either medical or behavioral conditions may not be the physician's professional choice at any one point in time. However, a knowledge of the behavioral aspects surrounding the individual or family should be sufficiently developed so that the family physician knows when referral is appropriate, and when symptoms treated only medically deny the human, existential problem presented by the patient, family, or community.

Schein has outlined seven conditions that facilitate the process of role innovation in the education of the professional. Briefly, these conditions framed in the context of family practice are as follows:

1. Family medicine faculty must be anchored in disciplines and oriented to research and scholarship, rather than being exclusively oriented to practice per se.

2. The family medicine faculty should include the behavioral sciences and the humanities in order to stimulate intensive analysis of value issues, of humanistic questions, and of the role of the profession in society.

3. The curriculum must facilitate the student's or resident's involvement in projects which force him to make intellectual and personal commitment from which he obtains immediate and relevant feedback.

4. The curriculum must train the student or resident in the ability to diagnose complex social systems.

5. The curriculum must train the student or resident in the skills of intervening in social systems (particularly the family) and initiating constructive change processes through the utilization of behavioral science knowledge.

6. The curriculum must create opportunities to learn to work with other people in team or group settings.

7. The family medicine curriculum and faculty must help support the early career of its graduates to insure that the values and skills which were nurtured during school continue to survive in the early and formative years of practice.

Understanding and meeting these seven conditions certainly causes the faculty to look beyond the management of any single resident/patient problem or the location of new reference sources for lecture presentations. To address adequately the ethical imperative of role innovation, behavioral science must truly become an interdisciplinary concern of family medicine.

In order to devise appropriate teaching approaches, the Division of Behavioral Science in the Department of Family Practice of the Medical University of South Carolina has articulated 37 objectives under six specific headings: (1) the family, (2) the community, (3) resident self-understanding and awareness, (4) ethics and value systems, (5) role and function of the family physician, and (6) psychotherapies and counseling skills.[1]

In all, approximately 121 half-days are formally structured in the three-year family practice residency to teach behavioral science. Additional time is devoted to behavioral science as a matter of individual resident choice. One half-day provides approximately three contact, experience, or teaching hours. Thus, we have found that 363 hours of formally structured behavioral science teaching constitute the minimum time allotment if that aspect of the resident's education is to be treated adequately.

Comment

Within the discipline of family medicine and the new specialty of family practice exists the potential for a real transformation in the character of American medicine. This transformation will significantly modify the quality of health care available in America. That modification will take place as soon as each family practice program addresses in its teaching the second ethical imperative of role innovation described above. In other words, thinking and acting must first be directed by a professional concern for society. Then family practice must negotiate a new contractual relationship with the individual and society that preserves the older elements of medical practice only where they honor the new contract. Finally, the transformation of the character of American medicine cannot take place in a humanistic way until the physician himself comes to realize and express his full human potential. Thus, each family practice program must keep in mind the first ethical imperative articulated above, that behavioral science teaching address the physician as a person. It is the person of the physician that must become the primary diagnostic and therapeutic "tool" of family medicine if the new discipline of family practice is to become truly human and truly responsive to the needs of society.

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