Family Practice Forum

Attitudes of Family Practice Residents

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The first months of a family practice residency are a challenge to the individual, especially in acquiring an identity as a family physician. This task appears to be harder than the acquisition of a new identity by a resident in a specialty older and more well defined than family medicine.[1] Not only may the identity of the family practice resident be ill defined, but there may be no consensus concerning the identity of a typical family physician in private practice for the new resident to accept as a model for his/her future. Residents in other specialties have the advantage of a clear prototype and are not stressed by changing roles as is the family practice resident when moving from one specialty rotation to another. Yet, the new resident is expected to somehow acquire an identity as a member of a new category of physicians. This identity is intended to provide role definition and ego strength to permit acceptance of one's relative lack of knowledge and expertise on each specialty rotation.

New residents should be encouraged to consider attitudes which are relatively new to medicine and are developing within the discipline of family medicine. While the family practice resident is to gain knowledge, clinical skills, and new attitudes, the development of appropriate attitudes is emphasized least in the educational effort when compared to the development of skills and knowledge. Attitudes are probably best learned by the example of role models. The behavior of these

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models should be consistently based on ethical attitudes which are viewed as contributing to the physician's success, both as person and physician.

The Importance of One's Self

The first of these attitudes is in valuing the "person" or "self" of the physician as the most important element in the medical armamentarium. This is not a new idea,[2] but is overlooked in comparison with the value placed on other elements such as new drugs, complex respirators, or elegant nomograms. It is doubtful that patients have ever lost sight of the importance of the interpersonal relationship with their physician. This "self" includes the elements of knowledge, skills, and attitudes. Since family physicians share medical knowledge and skills with the other specialties, the element which makes family practice unique is likely to be attitudes, which are based on the primacy of the person.[3]

The "self" of the physician, and the attitudes as an element of that "self," function within each physician-patient relationship. An effort must be made to understand both those elements of the relationship: the physician as well as the patient. Efforts to study these relationships have generally focused only on the patient and they have failed to give physicians information to improve their interactions. Compliance studies show that the physician-patient relationship influences whether a patient follows the physician's advice.[4] The classic relationship of physician to patient is seen, in the transactional-analysis model, as parent (usually nurturing) to adaptive child. The invitation is inherent in each such interaction for the adapted child to become a rebellious child or to overadapt to excessive dependency. Further studies should focus on the physician as well as the patient: the transaction of physician (parent) to patient (child) should be modified more toward adult-to-adult interactions.

As a new resident, accepting this attitude would mean accepting a need for self-examination within each interaction with patients, leading to a continuing effort to achieve more maturity. Striving for this leads to opening one's self to study and to recognition and modification of one's faults, prejudices, needs, and strengths. Bown has said "it is only when we can express our own deepest needs that we are able to perceive the operation of those needs in another person, and it is only then that we have this basic response, which we need from other people, available to give to them."[5] To restate this, Alan Johnson feels that "what the resident does not know and experience in himself, he will find difficult if not impossible to identify in the patient."* In my experience, the greatest movement towards this personal understanding came while a patient in group psychotherapy.

Achieving the ability to become open to one's self is a continuing process requiring much effort and honesty. Complete maturity is probably like perfect health, impossible to reach or even define. The importance of a residency in this context is to foster the willingness to start the process and establish the habit of continuing self-examination. One could certainly become a successful physician in a monetary sense while refusing to get involved with self-awareness. Society leans toward rewarding the dramatic rather than rewarding personal maturity and autonomy. However, there are rewards for self-awareness. Perhaps the rewards are most manifest in a release from feelings of anger, depression, and resentment that are often the lot of a physician who chooses not to break out of the physician-parent role or out of his own prejudices. In addition, the more mature physician is able to have genuine empathy with and understanding of his patients.

Patient Autonomy

The second attitude is one of encouraging

*Johnson A: Behavioral science evaluation in the family practice residency, unpublished

maximum autonomy in patients. It is a natural correlate to the previously stated attitude encouraging the physician's autonomy. Ivan Illich's recent book is a challenge to the entire value system of present-day medical practice, especially regarding patient autonomy.[7] One of the early contributions of family practice was a willingness to reexamine the assumptions of medicine. "To restore the primacy of the person, one needs a 'medicine' that puts the person in all his wholeness in the center of the stage and does not separate the disease from the man, and the man from his environment—a medicine that makes technology firmly subservient to human values, and maintains a creative balance between generalist and specialist."[3]

The position of the physician as parent minimizes patient autonomy. The physician in the parent role tries to decide which problems he and the patient will address rather than allowing the patient to define this. He wants to be the one to ascribe the value or lack of value to each problem.[6] He jealously guards all the decision making for the relationship and dispenses only as much knowledge of the patient and the patient's problems as he sees fit. The options remaining to the patient are to accept the above, to rebel against all or some of these assumptions, or to overadapt and become increasingly dependent on and child-like toward this physician-parent. The physician is strongly tempted to think that his is a very powerful, mature role in this setting. Those patients who accept their role as here defined may secure better health, but not increasing maturity.

The public seems to be expressing a discomfort with the old roles. Legal experts repeatedly stress that the most critical element in preventing malpractice suits is securing a physician-patient relationship with which the patient feels comfortable. Consumer movements and feminist groups encourage each individual to learn much more about his/her body's functions, to question his physician more, and to insist on participating in health-care decisions. The federal government is exerting control over medical costs and is setting priorities rather than simply absorbing an increased share of medical expenses. Members of the medical profession can view these actions as attacks on their autonomy or can view them as evidence of the people's desire to resume more control over their own health. The emergence of family practice from general practice is largely the result of the public's desire for less depersonalized medical care—not a product of the medical establishment.

Maximum autonomy should be encouraged in each patient regarding his health. Certainly, there will be some people who do not want it. Others, because of their youth or mental impairments, will not be best served by forcing too much autonomy on them. However, most patients in family practice settings are outpatients and very unlike the critically ill, hospitalized patient in a teaching hospital with "one foot in the grave." (Even in those cases, many may be far more capable of rational thought and free will than the physician may presume.) By self-examination, the physician can try to avoid the parent position, and concentrate not only on identifying the signs and symptoms of illness but also on assessing the strengths of each patient upon which autonomy could be built. Both patients and physicians should view the physician's role as a health-care *facilitator* (the patient is ultimately the health-care provider). A facilitator acts to the patient as a consultant acts to the primary physician. The consultant, and the facilitator-physician, know they are presenting options—not making decisions. The choice between options remains the inherent right of the primary physician, and by analogy, the patient's. The atmosphere of a physician-patient relationship should be such that the patient feels free to admit he is not likely to decide to follow his doctor's advice. This would allow discussion of alternative options.

Learning

As there exists a classic pattern for physician-patient relationships, there exists a classic pattern for teacher-student relationships. In no branch of education does this relationship seem more firmly based on parent-adaptive child interactions than in medical education. The parent presents information which the adaptive child must regurgitate to win rewards from the parent. Possibly the pattern

of relating to medical students and residents in the same manner as one relates to patients is hard to break and the temptation to portray one's self as omniscient and omnipotent to those learning medicine is even more powerful than to appear this way to patients. But again, the dependence built into these transactions fosters resentment and discourages autonomy—the goal towards which medical education is supposed to be working.

Carl Rogers has suggested viewing a teacher-pupil relationship from the psychological perspective of therapist-client.[5] Leaman views the ideal atmosphere in these terms: "The responsibility for what happens in a teaching-learning situation rests on the student. The faculty's responsibility is to provide direction, point toward goals, offer means for learning, and assist in evaluation."[7] Achieving this atmosphere is a challenge and a gradual process for physicians, who can improve their ability to cope by using the adult position. Any movement to the adult position is a powerful invitation for the other party to reciprocate. It is harder for a resident to take this mature path; ie, to examine self, to establish patterns of lifelong education, and to work with the power and influence one has to revise a teaching program, than it is to remain in the well-practiced role of adaptive child for 36 months as a resident. It is the option of family practice teachers to work themselves to break the old patterns and to develop basic methods of instruction different from the classic methods of medical education.[8]

Comment

The foregoing is based on personal experience (having just completed a family practice residency), the experiences of fellow residents and of valued role models, and acquaintance with the thrust of much of the current literature in family practice. It is an attempt to discuss some powerful and productive attitudes which are relatively new (or at least relatively unsung) in medicine in general but which are becoming more prevalent in family medicine. Attitudes encouraging autonomy and leading to maturity are important to all involved: physicians, patients, students, and teachers. They result in better health. Acquired early in one's career, they offer the possibility of less gnashing of teeth and more enjoyment of learning.

Today, the greatest strength of family practice may be that it allows and encourages diversity, which enables family practice residents to develop their own identity as family physicians and maximizes their individual strengths and interests.

Acknowledgements

The author wishes to thank Dr. I. R. McWhinney of the Department of Family Medicine of the University of Western Ontario, Dr. Robert Nordling of the Department of Family Medicine of the University of Arkansas for Medical Sciences, and Peggy Strode, RN, for constructive criticism and encouragement with this paper.

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