Behavioral Scientist Meets The Practicing Physician

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The difficulty of integrating behavioral science into family practice programs is discussed by identifying (1) the problems arising from behavioral scientists, and (2) the problems arising from physicians. Some of the behavioral science issues discussed are miscommunications regarding the difficulty of understanding human behavior and empathy, and "sets" that affect diagnostic procedures and physician-patient interactions. Contributory issues discussed which arise from physicians include the post-Flexnerian model of medical practice and the question of values in the physician role.

With the growing emphasis on primary, comprehensive care, physicians and especially family physicians, are seeking to enhance their human interaction skills.[1-4] It is the emotional and interactional aspects of physician functioning that underlie the felt need for increasing "primary, comprehensive" care rather than improved technical skills, since physician training in the technical aspects of the physician role has been increasingly sophisticated and expert over the last 40 years.

The result is that physicians are willing—even eager—to learn from the body of knowledge called behavioral science. Behavioral scientists on the other hand have, for years, been eager to share this body of knowledge with physicians. Yet, a really workable relationship has yet to develop despite the best of intentions. Nearly every encounter between the two has generally been ineffective at best, or counterproductive at worst.[5-7]

The reasons that contribute to this mismatch are probably multitudinous, but during the experience of trying to relate to residents in a family practice setting certain assumptions, sets, and attitudes have been encountered that might help in understanding better what some of the problems are in joint communication and how all concerned might better proceed.

Problems Arising From the Behavioral Scientist

Understanding Human Behavior

A fairly common assumption, never verbalized but implicit in many behaviors and explanations, is that understanding human beings is a terribly dif-

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ficult, complex, and exhausting task. Perhaps behavioral scientists have been too successful in communicating the complexity, the involuted and dark richness of human functioning. Equally true is the fact that all of us have a great deal of understanding about human beings. We would never be able to function successfully unless we did know a great deal about how people respond to situations, what people want, and what makes them feel good or feel bad. But a curious kind of dichotomy seems to exist whereby what physicians do know about the emotional functioning of human beings seems so ordinary and usual that it doesn't count, while "real" understanding is a time-consuming, never-ending, complex process represented by their past experiences with psychiatry.

This assumption has several consequences. First of all it precludes valuing and using effectively or systematically what physicians do know. Or even using it at all. Secondly, it prevents adding to the knowledge physicians already possess. If "real" understanding takes so long to achieve (look at the training it takes to be a psychiatrist) there is little point in moving in that direction unless a change in specialty to psychiatry is desired or unless an emphasis on the treatment of "that kind of patient" is anticipated.

Another consequence of this assumption is that dealing with the emotional, motivational aspects of patient behavior is seen as only necessary for difficult patients. Physicians are less aware of the skills and understanding of human behavior they are using with "normal" patients, and that these same skills and understandings can be extended to more difficult patients.

It is perfectly true that physicians see some patients whose whole life is in such disarray that it would take the third army to begin to make a dent in the situation. But very small interventions can often be made using the skills physicians do possess that then may create ripples of positive effect. It is understandable that one would be reluctant to attempt even a small behavioral intervention in the face of a multiple-problem patient while holding the belief that nothing short of a "deep" understanding of the patient's "dynamics" is likely to make a difference.

The second major assumption frequently encountered is that being empathic means being a bleeding heart, loving everybody, caring about everybody, being sympathetic about everything, extending unlimited time and energy to everybody, or at least to those who seem to need more than the "normal" interaction. Given this assumption it makes perfect sense to conduct business in such a way as to avoid opening up any issues that might call for empathic behavior. It is quite probable that most behavioral scientists, at some time in their training, shared this assumption, and one quickly learns, either through supervision or experience, that such a stance is unrealistic, self-destructive, and not good patient care. Obviously the factor left out of that equation is the "self" of the physician. Some of the most empathic physicians are very tough, are clear about their own values, the time and emotional demands they are able and willing to meet and those they are not, and are able to communicate this to patients in very straight messages. There are physicians who make beautiful, straight, helpful statements to patients, such as "I'm not going to prescribe a tranquilizer for you because you can find better ways of coping with your stress," yet some of these physicians still apologize for being nonempathic or impatient! Here is a basic misunderstanding and perhaps it has something to do with not having a shared, common language.

Language Systems

The English language being what it is, frequently people use a word assuming it has a universal meaning, eg, sex, when in fact it has very different meanings and behavioral manifestations for the others involved in the communication. How much more easily can misunderstandings arise with specialized language systems, such as the jargon so dear to the hearts of behavioral scientists.

The language system of psychoanalytic theory will serve for the purpose of illustration. Although probably no better or worse than any of the others in terms of jargon, it does have one unique characteristic, and that is the perjorative flavor of its language system. Consider the labels of some personality types: "obsessive-compulsive, hysterical,

narcissistic, psychopathic, paranoid." Those do not sound like very nice people. Or again, consider some of the labels of the ways people survive the stresses of living: "repression, reaction formation, isolation, denial, displacement, rationalization." These do not sound like very desirable behaviors.

The importance of the perjorative flavor of this language system is twofold. First, people tend to reject viewing themselves in a negative light, so that it is very difficult to accept those terms as having relevance to oneself, and if forced upon them, produce a good deal of discomfort, anxiety, or anger. Secondly, this language is used most often when talking about patients. A physician, or anybody else for that matter, might not be as uncomfortable hearing someone other than a patient described in those terms, but again, it makes those described sound "sick" and different from the speaker. This contributes to the we-they distance between physician and patient, as well as makes the understanding of other people mysterious, difficult, unattractive, and unrelated to personal experiences.

Sets

A "set" is a way of thinking that directs and channels how one handles and deals with whatever one is thinking about. One set commonly encountered in physicians is: "If it isn't organic, it must be psychosomatic." "Psychosomatic" becomes a wastebasket category. The physician is skilled and knowledgeable about organic causality and has a large battery of tests and equipment to help explore every possible contributor to the dysfunction. Once those are exhausted to no avail the only alternative is "psychosomatic." It is like working on a map which shows minutely detailed roads, signposts, landmarks, and elevations on one side, and blank space ("terra incognito") on the other.

Once a physician concludes the dysfunction must be psychosomatic, the patient is relegated to the unknown half of the map for the attention of almost equally unknown specialists. However, the other side of the map is not as blank as it appears. But obviously behavioral scientists have not done a very good job of filling in useful signposts to help physicians move back and forth comfortably. Just as there are signs and symptoms and information from the history that indicate the likelihood of an organic basis of a dysfunction, so too are there signs and symptoms and information from the history that indicate the likelihood of psychologic origins of a dysfunction. The ability to use both would lend itself to a more parsimonious diagnostic procedure than is presently the case.

A woman came in complaining about a pain in her leg. The resident examined her, could find nothing to account for the pain she was experiencing, made some recommendations to ease the pain, and sent her away. All perfectly appropriate. However, the woman returned complaining again about the pain in her leg. The resident, concerned that he might have missed something, made an even more thorough examination, still could find no cause, and asked for an orthopedic consultation. Still nothing could be found and the woman was again discharged, with appropriate suggestions. The resident felt uneasy that nothing much had been done about the woman's complaints, felt fairly sure that he would be seeing her again soon, and was planning to ask next for a surgical consultation. That clearly is working on one side of the map. Possibly after the surgical consultation found nothing to account for the pain, the woman would be labeled "psychosomatic" and referred to a psychiatrist. Using both sides of the map might lead to a different diagnostic procedure.

The woman presents complaining of leg pain, is examined with negative findings, given recommendations for the pain and released—so far the same. When the woman returns complaining of the same pain, the resident, knowing that he had done a complete and competent job the first time (which he had), considers the possibility of somatization of psychic stress. Therefore, he does a careful investigation of the current life situation, past history, and psychosocial environment that accompanies the onset and duration of the pain to discover those indicators of the likely psychogenic origin of the pain. Depending on those findings, he might choose to refer to a psychological specialist, to intervene in the patient's psychosocial functioning himself, or to proceed to further investigation of organic causality.

In any case, it would seem that all involved would benefit from this procedure. If the psychosocial history indicated a high probability of psychic involvement, the patient is saved multiple examinations, tests, and hospitalizations. If the psychosocial findings indicate a low probability of psychic involvement, the resident has a little more confidence and motivation to explore with the second set of tests. In other words, by using only one side of the map, diagnostic procedures tend to escalate in terms of time, money, and drastic measures in the face of the unknown. After all, physicians do want to help their patients, they want to do something about their complaints and so they do, using the tools and techniques with which they are most familiar and comfortable.

A second set has to do with the tendency to view all interpersonal transactions as based only in the individual and to overlook the impact and causality that can come from the interaction between individuals, rather than from the individuals themselves. A woman called asking that an appointment for her 80-year-old father-in-law be rescheduled at an earlier time as he was in a great deal of pain. The clinic was responsive and went to a great deal of trouble to schedule him early. Then followed a whole comedy of errors with different members of the family speaking to different members of the clinic until there was utter confusion as to when exactly the old man was to be seen. This episode ended with the husband (a prominent businessman) calling the resident in anger to say what a rotten doctor he was, how unresponsive and uncaring. The resident was a little miffed himself, defensive, angry, and happy to wash his hands of the entire situation. As an observer I was sad to see two parties, who were both "right," end up with such negative feelings. There was a good deal of discussion following that episode about what had happened and who was to blame. If one is sitting in the clinic, most of the blame and bad behavior end up on the patient's family. It is likely that just the opposite was taking place in their home. Actually, nobody was to blame. The resident was perfectly correct in feeling he had been unjustly accused because he had indeed made every effort to meet the needs of the family. It would have been helpful if he could have seen that the fault lay in the interaction and not in him or in the patient's family. Some understanding of that would have allowed him to feel less personally attached, less defensive, and may have allowed him to deflect the patient's family's feelings into a happier and more constructive ending.

Self-Knowledge

To understand interactive effects it is necessary to have some idea of what one personally brings to that interaction. So far behavioral scientists have done a poor job of helping physicians recognize the qualities they bring to interactions. Behavioral scientists tend to focus so much on patients and patient care that a belief can develop that the physician is like a blank screen facing all these different kinds of patients. The focus is on what the physician can do and what the patients are like. But after all, physicians are as variable as patients, both being human. Some are tall, some short, some smile a lot, others don't, some appear easy going, some seem stiff, and people respond to these cues and alter how they relate to them accordingly. Obviously there is no one right way to be. There are excellent stiff physicians and excellent easy-going physicians. But it is helpful to know how one is likely to be perceived by other people as this helps both to understand and to control the interaction.

A resident had a follow-up visit with a patient in which he had to break some fairly sensitive and not very happy news. Although this particular resident is not at all comfortable dealing with emotions, he did a very good job verbally, saying the right things in the right words. But if he could have seen his own face, he would have seen himself grimacing, popping his eyes, waggling his eyebrows. What he was saying with his face was, "I know this is sensitive material—I really hate to say this—I hope you won't be too upset." The resident knew how he was feeling, but he did not know how those feelings were coming across or how they might be affecting the interaction. An opportunity to see himself as he is perceived by others would enable him to be more effective in dealing with many situations, both for the patient and for himself. This resident is representative of

many physicians who are not comfortable dealing with emotional issues and who therefore do not want to deal with them. That is a perfectly valid and legitimate stand. But no matter how carefully patients are screened some of these situations are inevitable. They have to be dealt with initially and, it is hoped, in a way that protects both physician and patient. It would be most useful to say openly, "I'm not very comfortable with this but I think you need somebody to talk to," and then suggest several sources to whom they might go. The point is, physicians who know something about themselves can do a better job at practicing medicine in a way that's comfortable and still see that their patients' needs are met—they do not have to do everything themselves.

Problems Arising from Physicians

Having discussed *how* behavioral scientists should teach, ie, use language carefully, develop common understandings, clarify concepts; and *what* behavioral scientists should teach, ie, self-awareness, interactional process; the larger question that only physicians can answer may be asked: *Should* behavioral scientists teach? This question does not concern the issue of whether or not behavioral science input is the prerogative of psychiatry, psychology, sociology, social work, or anthropology. That issue is trivial and reflects power concerns rather than substantive issues. Obviously, "behavioral science" content is incorporated in the expertise of many disciplines; what is important is not who teaches behavioral science, but what is taught and how it is taught. The question raised here has not so much to do with teaching, as with whether there are any learners.

It is true that physicians say they want increased understanding and skills in the psychosocial aspects of practice. But even when these skills and understandings are demonstrated to show how they may affect practice and even when they have been experienced (physicians can be very enthusiastic about the experience), physicians still ask the legitimate question, "But is it really useful to the practice of medicine?" In other words, is it more than just a frill? When somebody asks that question but has not experienced a physician-patient interaction while using those skills and understanding, one can assume it is a simple case of not knowing or understanding. But that the question still exists after successfully developing and using those skills can either be depressing or signal that the problem lies elsewhere than in the simple lack of acquisition of these skills.

It is generally recognized that traditional medical schools have evolved largely into major biomedical research centers.[8,11] The emphasis in medical schools (for many reasons) has been on the fostering and development of the technical aspect of the physician role.[9,10] The term physician has come to mean expertise in diagnosis and treatment with the aid of very complex instrumentation and specialized biomedical knowledge. This shift in emphasis has led to a mass social action that protests this change in values in the medical profession. In pre-Flexnerian days it was axiomatic in medical education that physicians be trained to consider the total world of the patient because the educator was a practicing physician who was treating patients in that manner and who had himself been trained in that way. The clamor from the public[1-4] reflects a desire for a return to the values of that earlier method of training. The elevation of family practice as a specialty and the funding attention given to it would seem to indicate that it is being viewed as the "great white hope" of the present widening-gap dilemma between the technical expertise in which physicians are trained and the expectations of society for personal as well as technical medical care. One of the primary goals of family practice residency programs is to add to their usual outstanding technical training the skills and understandings of human behavior that will enable them to deliver that medical care in a personal, family-oriented context. However, there are two major problems in achieving that goal.

The first is that there are very few models for the teaching of this integrative medical care. Most physicians have been trained in the last 50 years during which time high prestige and respect went to those most expert in the technical aspects of the physician role. Secondly, when the family practice residency programs do begin to incorporate the behavioral sciences meaningfully into the curriculum and practice, physicians run the risk of lowered prestige, scorn, and belittlement usually

associated with the "soft" sciences. This often leads to an abandonment of the behavioral aspects of practice, with physicians citing as reasons lack of time (I'm too busy being a real doctor), or lack of usefulness (it doesn't help in treating a cold or cancer, or it doesn't really change what I do). Sometimes it leads to an intensification of the technical aspects of the physician's role to show that one is every bit as good a "doctor" as those in the other specialties.

Understandable as this all may be, it presents family practice with a tremendous task. To achieve their own stated goals and meet the needs they hope to meet, family physicians may have to singlehandedly change the role definition of physician. Singlehandedly because there is not much reinforcement around in the medical profession for truly integrated practice. Singlehandedly because it takes a lot of courage and conviction to stand up to criticism and slurs from one's colleagues. One physician, who from observation really does practice an integration of both the technical and psychosocial aspects of medicine, described the criticisms he received from his colleagues, ranging from he was not carrying his share of the load in the community to he just liked to loaf; others report being called "Dr. Welby" in contemptuous tones. This physician was firm in his conviction that, right or wrong, this was how he was comfortable and liked to practice medicine. It seems a shame that one who would seem to be an outstanding example of a family physician should have to defend himself against being "wrong." And yet that would seem to be the prevailing Zeitgeist in medicine today.

The problem, then, is that family practice must really address itself to what "role of physician" it wants to develop. Although a good deal of lip service is paid to wanting behavioral sciences, have the implications of obtaining input from behavioral science and implementing it been carefully thought through? If behavioral science really is implemented in practice it changes how one does things, how time is spent—in short it affects how one behaves as a physician, which in today's medical society makes the physician different, and in some eyes, not a "good" doctor. There is little point in family practice adding behavioral sciences to an already overloaded curriculum if in real life the behavioral sciences are to be ignored or reserved for "special" cases.

It is to be hoped that the charge to meet the values that society wants in the practice of medicine rests not totally on the shoulders of family practice. The newer medical schools are including these goals in the basic education of every physician, with about the same success and for the same reasons that family practice is having difficulty. But the issue is more pertinent for family practice than for any other branch of medicine. Essentially, what has been learned is that behavioral science expertise cannot be grafted onto the existing role definition of physician. The role of physician has to change to meet the needs of the society it serves. In that changed role definition behavioral science expertise can be incorporated. Until that question is addressed one can legitimately ask "Does anyone really want behavioral science input?"

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