Behavioral Science and Family Practice: A Status Report

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The purpose of this study was to assess the current status of behavioral science instruction in family practice residency training programs. The primary areas of interest were: (1) characteristics of those who teach behavioral science (number of persons teaching behavioral science by discipline and academic degree, number and percent of time behavioral science personnel employed, work responsibilities, academic unit responsible for instruction, description of those who provide inservice training in behavioral science), (2) the relative importance of various behavioral science topics as perceived by faculty/staff (21 topics), and (3) preferred methods of instruction. The data revealed a wide variety of persons involved in behavioral science instruction, a strong emphasis placed on communication and counseling skills, and similar, but not innovative, teaching methods used for behavioral science instruction.

The rapid proliferation of family practice residency training programs in the United States since 1969 has brought with it the development of a new aspect of residency training—namely, behavioral science. After nine years the term "behavioral science" remains ill-defined, an umbrella term not unlike "family practice" itself. Even though the American Academy of Family Physicians and the Department of Graduate Medical Education of the American Medical Association refer to the inclusion of behavioral science as essential to a residency training program, the guidelines of both organizations regarding the behavioral science component remain healthily broad.[1] Such breadth permits experimentation and the expression of various points of view. Consequently, some programs include almost no behavioral science, while others are affectionately referred to as training grounds for medical social workers.

No intention is made here to criticize, for it seems appropriate to find such divergence at this stage in the development of the family practice discipline. There is benefit, however, in describing that variety at its present stage. Therefore, the present study was designed to assess the current status of behavioral science instruction in family practice. The primary areas of interest were: (1) the characteristics of those who teach behavioral science, (2) the relative importance of various behavioral science topics as perceived by faculty/staff, and (3) preferred methods of behavioral science instruction.

Method

A questionnaire was sent to 286 accredited family practice programs in the United States, as identified by the American Academy of Family Physicians. Each program director received a

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Table 1. Number of Persons Teaching Behavioral Science By Discipline

Discipline		Number	Percent
Medicine		139	46
Psychiatry	(93)		
Family Practice*	(37)		
Internal Medicine	(4)		
Pediatrics	(3)		
Neurology	(2)		
Psychology		78	26
Social Work		42	14
Counseling		24	8
Other		21	6
Theology	(5)		
Sociology	(5)		
Anthropology	(2)		
Health Education	(2)		
Media Education	(2)		
Nursing	(2)		
Management	(2)		
Hospital Administration	(1)		
Total		304	100

*Family practice and family medicine were combined.

three-page questionnaire, a cover letter explaining the purpose of the study, and a preaddressed, stamped return envelope. Only those questionnaires (N=136) completed and returned before March 1, 1977, were included in the study. This represents a 47 percent response rate, which is an acceptable return rate for data analysis.[2] No attempt was made to pursue nonrespondents.

Results

Who Teaches Behavioral Science?

Table 1 indicates the number of persons teaching behavioral science by discipline. Forty-six percent were physicians and 54 percent were nonphysicians. Of the 139 physicians teaching behavioral science, 46 percent were psychiatrists and 27 percent were family physicians. Of the 165 nonphysicians, 26 percent were psychologists, 14 percent social workers, and 8 percent were counselors. The remaining 6 percent came from a variety of disciplines.

Of the 304 persons identified as teaching behavioral science, 46 percent were physicians; 29 percent held other doctoral degrees (ie, PhD, EdD) in a behavioral science related discipline; and 6 percent held bachelor's degrees. Table 2 displays the number of behavioral science faculty/staff employed per family practice department. Eighty-nine departments employed from one to three persons. Considering both extremes, 34 departments had four or more, but 13 departments employed no one to teach behavioral science.

With regard to the percent of time employed in family practice for persons teaching behavioral science, most of the persons teaching behavioral science were employed in the 1 to 25 percent (N=139) and 76 to 100 percent range (N=108). Most of the part-time persons were shared with the department of psychiatry (N=60) or psychology (N=12), or with private practice (N=17).

The people teaching behavioral science were found to have multiple responsibilities. The majority of faculty/staff members were involved in patient care (N=202), while many were involved in administration (N=95) and research (N=65).

Table 2. Number of Behavioral Science Faculty/Staff Per Family Practice Department		
Number of Faculty/Staff	Number of Family Practice Departments	Percent
0	13	10
1	29	21
2	35	26
3	25	18
4	15	11
5	16	12
More than 5	3	2
Total	136	100

Family practice is responsible for behavioral science teaching in 45 percent of the programs; psychiatry is responsible for 26 percent. The remaining 29 percent is made up of administrative, behavioral science, and psychology units.

Psychologists and social workers comprised 48 percent of those who provide inservice training to faculty/staff; psychiatrists and family physicians, 47 percent; and a variety of disciplines provide 5 percent. Of the 136 programs for which completed questionnaires were received, 60 indicated the provision of inservice training in behavioral science for faculty/staff, and 61 indicated no such provision; 15 did not answer the question.

What Do They Teach?

Table 3 represents 21 behavioral science topics as ranked by 136 programs. Interviewing and interpersonal communication skills received the highest ranking (1 and 2), respectively, among programs. Various forms of counseling and developmental concerns fell within the top ten rankings.

How Do They Teach?

The most frequent instructional methods used for teaching behavioral science topics were consultations, lectures, and seminars (Table 4). The methods least used were self-instructional materials, trigger films, and an "other" category (workshops, preceptorships, and audio tapes).

Discussion

Several significant matters come to light as the characteristics of those who teach behavioral science in family practice are reviewed. First, it can be taken as an act of courage on the part of those physicians who direct family practice residencies to involve behavioral science personnel in their residency programs. To invite such different people—their training, their technical language, and their ways of conceptualizing—into one's training program can only be considered daring. Further, the decisions involved in hiring such a large percentage (54 percent) of non-physician faculty are worth noting. No doubt, these individuals are more alien to the family physician than psychiatrists. Although it is fiscally sound to hire non-physicians over physicians in these roles, availability, and a host of other issues must play a part in these decisions. That 75 percent of those who teach behavioral science hold doctoral degrees can be taken two ways. On the one hand, it is refreshing to see that fully one fourth of the teachers do not hold doctorates. This implies a confidence, a lack of academic snobbery, and a bit of pragmatism. On the other hand, residents may more readily relate to a teacher who is called doctor. Finally, a word should be said about the wisdom of engaging a specialist to offer assistance in his special field. Not only can the specialists offer expertise in areas of knowledge not immediately available to most physicians, but the very nature of the consultation and translation process can

Table 3. Rank Order of Behavioral Science Topics

Rank*	Weighted Score **	Behavioral Science Topic
1	710.60	Interviewing skills
2	663.17	Interpersonal communication skills
3	412.00	Marital counseling
4	352.23	Family life
5	337.28	Individual counseling
6	287.82	Family counseling
7	286.02	Normal and pathological psychosocial development (infant to geriatric)
8	285.64	Brief psychotherapy
9	212.91	Sexual counseling
10	197.76	Human sexuality
11	187.06	Psychological and sociological influences on the family and health care
12	171.00	Concepts of death and dying
13	159.00	Group counseling
14	142.10	Management of common childhood problems
15	116.10	Personal growth experiences
16	104.14	Practice management
17	99.16	Medical ethics
18	92.14	Patient education
19	90.00	Physiological correlates of behavior
20	83.97	Preventive behavioral health maintenance
21	66.92	Drugs (therapeutic, illicit, etc)

* 1=Highest rank
** Due to unequal Ns a weighting system was used.

prove quite stimulating to both parties.

The fact that 34 departments of family practice employ four or more behavioral science faculty members is impressive. Such a staff surely indicates a substantial commitment to the teaching of behavioral science in family practice. It is possible that these programs are the ones to which family practice can look in the future for research and leadership. It is presumed that those programs showing no behavioral science faculty members are newly formed.

The data on percent of time employed to teach appeared to reflect two different philosophies—the part-time philosophy and the full-time philosophy. Presently, perhaps because of economic considerations, the part-time philosophy is represented in greater numbers of programs. It is understandable how this and other administrative considerations may play a part in allocating resources within a family practice program. It is also clear how a part-time faculty member may supply needed input to other faculty members in a highly

Table 4. Method of Behavioral Science Instruction

Method	Number*	Percent**
Consultation	110	81
Lecture	108	79
Seminar	102	75
Clinic critiques	82	60
Video feedback	80	58
Live demonstrations	62	46
Role playing	55	40
Human relations training	50	37
Self-instructional materials	33	24
Trigger films	22	16
Other	11	8

*Number=number of programs using each method.
**Percentages are based on responses of 136 programs.

specialized area. However, if one is committed to the preparation of competent physicians, people who know how to perform, then the full-time availability of clinically skilled behavioral science faculty becomes a high priority. There is simply no substitute for the teacher who can make specific clinical application in the day-to-day case situations encountered by resident family physicians. In short, the teacher should back his words with action.

Teaching predominates faculty/staff functions. This is as one would expect. That behavioral science faculty members are engaged in a number of additional activities seems to express confidence in these individuals' ability to assume responsibility. It seems natural for them to be involved in patient care in the substantial way that the data imply. It is possible for behavioral science faculty members to become bogged down in too much patient care, and, at times, behavioral science faculty do complain about being used as a "dumping ground." If the faculty member establishes guidelines for himself, uses good judgment in specific situations, and has the support of the director of the program, he/she can take advantage of the dumping move by the resident as a teaching opportunity. In this instance, the faculty member can begin to break down some of the prejudices which residents sometimes bring with them, eg, "good" vs "bad" patients, "crocks." It is a good sign to see that behavioral science faculty have research responsibilities; however, only 65 were so engaged at a time when much interest, education, and financial support are needed for research endeavors.

As one peruses the data on the academic unit responsible for behavioral science instruction, it seems unfortunate that in only 45 percent of the programs is family practice the responsible unit. It is unclear whether fiscal, political, or other matters influence such decisions. In order to integrate, translate, and apply the various behavioral science concepts and techniques with family physicians, it seems critical to understand the day-by-day work of the family physician. Such understanding is difficult to obtain as an outsider. To be meaningful to family physicians, behavioral science must accommodate to family practice rather than vice versa.

It is very encouraging to see that 60 family practice programs have instituted inservice behavioral science teaching for their faculty. Physicians are certainly not immune to the reluctance most people have when acknowledging ignorance in an area or submitting to the teachings of another. Such widespread inservice training suggests many

promising possibilities for the future of family practice. It allows for more adequate and complete role models in the form of family practice mentors, and consequently may lead to a much better integration for the resident of family practice as a whole. The day may never come when all family practice teaching is done by family physicians with consultants active more in the background than in the foreground, in so far as residents are concerned, but such a model has many appealing aspects.

In spite of the fact that more psychiatrists than psychologists are employed by family practice programs, more psychologists than psychiatrists are engaged in inservice training of family practice faculty. One can only speculate as to the reasons for this. Perhaps this reflects a feeling that traditional psychiatry, as such, is insufficient to meet the needs of the family physician. Behavioral science is not confined by psychiatry but is a much broader field. Then, too, psychologists may be hungrier or more adaptable than psychiatrists. No doubt, several factors have played a role in these decisions.

According to the ranking of topics taught, the current focus of behavioral science in family practice is the physician-patient relationship. Overwhelmingly, the emphasis is on communication skills and various forms of counseling. This emphasis may change, but the intention, and probably the action, of the nation's programs are clearly in "bedside manner."

Family life was highly rated, as it should be. Although some programs have developed a family-oriented approach to health care, most programs remain locked into the one-to-one delivery model. In spite of family life's high rating, most programs still find it genuinely difficult to change radically such a basic orientation. The reader may find it helpful to keep in mind that the topic's current importance was rated and not the amount the topic was actually being taught.

An interesting comparison can be made between the rank of family life and group counseling. Most agree that group counseling should fall lower than family life, but the commonality is found in that neither has been adequately incorporated into family practice even though both are accepted as important to family practice. Behavioral science faculty have not yet made clear just how group approaches can be useful in family practice; they may not yet know themselves.

Somewhat surprisingly, the topics of patient education and preventive behavioral health maintenance were rated very low even though each has been recognized as a significant aspect of family practice.[4] These areas may well be taught less often in an identifiable unit than as a part of an overall attitude about patient care.

An examination of the data on methodology suggests that behavioral science faculty are slow to move toward the more modern, technical, and instrumented teaching methods. No doubt, consultation will always remain a standard teaching method in a clinical field such as family practice, but perhaps there are other reasons to resist change. One reason is obvious: people resist change. Also, most behavioral science teachers have surely sat through a "lecture" on how valuable newer teaching techniques can be, as opposed to the lecture. Most teachers have been taught through teacher-centered, not learner-centered approaches. The medium may well again be the message.

In summary, the intent of this study was to present the current status of behavioral science instruction in family practice residency training programs, as perceived by those responsible for such instruction. More specifically, data were presented that describe characteristics of those who teach behavioral science, what behavioral science topics are stressed, and how behavioral science is taught. No attempt was made to differentiate between community-based and university-based programs. Such a distinction may prove useful in further study of this area.

References

1. American Medical Association: Special requirements for residency training in family practice. In Essentials of Approved Residencies. Chicago, American Medical Association, 1968
2. Backstrom CH, Hursh GD: Survey Research. Evanston, Ill, Northwestern University Press, 1963
3. Conn HF, Rakel RE, Johnson TW: Family Practice. Philadelphia, WB Saunders, 1973, pp 310-323
4. Rakel RE: Principles of Family Medicine. Philadelphia, WB Saunders, 1977, pp 142-149