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Patient Discussion Groups in the Training of Family Practice Residents

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Family medicine educators have recently been exposing residents to new and sometimes radical interpretations of the disease process. Most of these interpretations are based on a phenomenologic model implying that how a patient perceives his illness is of equal or greater importance in the therapeutic process than the specific pathophysiologic aspects of the disease. Residents are being urged to view disease as a manifestation of a breakdown in a patient's personal and social, as well as physiological, functioning. While this more holistic concept of disease is not new, it is only recently that attempts have been made to incorporate it specifically into the training of physicians. The writings of George Engle,[1] Jerome Frank,[2] and Anthony Reading[3] are excellent resources in this regard, but they do not give guidelines for the teaching of these concepts to physicians-in-training. The purpose of this communication is to suggest one approach which has demonstrated some success in establishing a patient oriented approach to illness in a family practice residency.

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Rationale for Use of Patient Discussion Groups

The use of patient discussion groups as a teaching device for residents came, for this author, following a number of frustrating experiences using a didactic teaching method with residents. While I had heard throughout my residency that it was important for family physicians to "treat the whole patient" and "see the patient and his illness within the family constellation," how one went about developing this approach was not well defined. Didactic discussions around issues such as the role of stress in illness, the magical and ritualistic aspects of physician-patient interrelations, and the

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symbolic meanings of illness to patients, while interesting, did not seem applicable or translatable to a resident's day-to-day dealings with his own patients. It became clear that if residents were to accept a model of disease which included personal and social phenomena, then the model would have to be presented in a more practical form and preferably would come "directly from the horse's mouth." The use of panels of patients sharing with residents the personal aspects of their illnesses and life situations seemed to be a practical and ultimately credible solution to this problem.

Types of Patient-Resident Discussion Groups

A variety of such patient-resident discussion groups have been established by a number of the faculty at the University of Colorado Department of Family Medicine. A typical arrangement is to identify a number of patients or families with a specific medical problem or life situation, for example, having a new child in the house, having a particular chronic illness in a family member, or being a three generation family. These discussions are moderated by a faculty member or members but quickly become open discussions including patients, residents, and faculty. Another successful approach has been to select an undifferentiated group of patients and to raise questions in and around the process of being ill. These discussions have generated conversation between patients and residents around such issues as patient compliance, the expectations patients have of their physicians, and the way patients respond to different kinds of physician styles. This format gives the chance for residents to hear directly from patients what it is that they do that their patients like and do not like. Residents hear everything from what it is like to try to talk to somebody while you are in a flimsy patient's gown in a cold room, to what it feels like when the physician uses words that you do not understand.

Discussion

Residents and patients seem to enjoy this group process immensely and what transpires seems to be not only informative but therapeutic as well. In a recent discussion, a resident shared some frustration in his inability to know what to do when a patient conveys a complicated personal problem. One of the patients on the panel responded by saying that often patients do not expect solutions when they convey personal problems to their physician but often get a great deal of relief by being able to share that information with someone who conveys a caring attitude. This may have been the first time that any of those residents had heard a patient say that patients do not expect us to solve all of the problems that they come to us with. On another occasion a resident mentioned that he had a great deal of difficulty charging people for visits when all he did was "talk" with them. The patients responded by agreeing unanimously that they were more than willing to pay for a physician's time when he did nothing more than listen and respond in a caring way to their problems. This honest sharing of points of view between patients and residents encourages us that the model may be useful in exploring many of the personal aspects of not only being sick but caring for the sick as well. For the residents, the opportunity to hear patients share their fears and expectations provides a sanction for a new and more therapeutic approach to their own patient's problems.

Conclusion

Educators in family medicine have committed themselves to a patient and family centered approach to disease. This paper suggests one possible approach to that task. The patient-resident group discussion provides residents as well as patients with a forum to share their own perceptions of illness behavior. This technique will be used at this training program in the future as a means of exploring other aspects of the phenomenology of illness and disease and of the physician-patient relationship.

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