Medical Education and Patients' Psychosocial Needs

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The article by Robinson and colleagues[1] in this issue of the *Journal* should be of great interest to medical educators *and* practicing physicians. This study of primary care physicians' counseling of patients who disclose psychosocial problems adds substance to the emerging idea that we have a long way to go to completely grasp the psychosocial dimension of primary care. In the study population, primary care physicians counseled 60% of the patients who disclosed psychosocial problems. But what about the 40% who disclosed psychosocial problems and received no therapy? This is a vexing issue. Repeated studies[2] have indicated that the primary care clinician is the backbone of the mental health system in this country, but the study by Robinson and coworkers calls into question our ability to effectively perform this function. To fully understand the genesis of this problem, we need to revisit the history of medical education in the United States.

Before the Flexner Report of 1910,[3] the American medical education system was a true hodgepodge of experiences. These ranged from sincere, though still fledgling, university-level efforts to expand the scientific underpinnings of medicine, to community preceptorship-training culminating in MD degrees being granted by state medical societies. To further complicate the issue, the states' medical-society degrees were conferred following varying testing procedures. Flexner's report accelerated the process of embracing of the scientific method and the use of reductionism as a methodology for scholarly inquiry.

There is compelling logic to the reduction of complex issues to component parts for vigorous study so as to better understand the whole issue. However, this process carries with it the risk of losing those qualities that make the complex issue what it is; the whole is greater than the sum of the parts. As Engel[4] so eloquently stated, "The crippling flaw of the model is that it does not include the patient and his attributes as a person, as a human being."

In the post-Flexner era, medical school curricula became increasingly standardized, and the academic health science center emerged as a reservoir of talent and research capability. As a result, the ultimate expression of reductionism emerged in the form of contemporary subspecialists, and they became the prototypical medical scientists and role models for generations of medical students. Lowes[5] summarized the end result of this when he stated: "The medical education system has taught doctors to see patients as disease puzzles to be solved rather than as people to listen to." Although it was hailed by many, some believe this process has produced a disruptive disequilibrium in the health care system. Subspecialists with their built-in predilection for reductionism are a necessary part of the process of care; however, they should not dominate the system at the expense of the compassionate, comprehensive caregiver who is adept at counseling. In the best of worlds these frequently disparate entities would be assimilated into a cohesive whole, but in the real world, sadly, it appears that the art and science of medicine are practiced in different ratios depending on the characteristics of the clinician. Former United States Surgeon General C. Everett Koop's[6] sentiments in this regard were well stated: "While the science of medicine has flourished, the art of medicine, which is largely the art of communication or relationship building, has languished."

This comment gets to the heart of the issue, and there is an expanding body of knowledge that supports this position. Earlier in this decade, Epstein and colleagues[7] observed: "Until recently the content, structure, and function of communication between doctors and patients has received little attention and has been excluded from the realm of scientific inquiry; as a result, most clinicians have had little formal training in communication skills." As an extension of this, Jackson[8] concludes: "The place of listening in depth and with empathy is a crucial element in healing. While the emphasis on looking remains significant in the gathering and appraisal of data, at times it threatens to overwhelm the need for an attentive and concerned listener."

These studies support the widely held contention of many primary care clinicians and educators that we need to make fundamental changes in the basic medical education process. Although significant lip service has been given to this during the past decade, there is meager evidence that it has happened. The results of the study by Robinson and colleagues of this dimension of the process of care could be interpreted as showing that we are not addressing the psychosocial needs of a significant number of our patients. To many interested persons this is not news. If you accept that communications skills are the building blocks of psychosocial care, then the current efforts to address these issues through contemporary medical education would appear to be more cosmetic and illusionary than real.

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Those of us who are practicing primary care medicine need to assert what influence we can on the medical education community. We need to continually inform and re-inform our educational colleagues of the disconnection between the scientific process of reductionism and the artistic processes of dealing with the whole patient. The contemporary physician must be adept at both, but we commonly see the predominance of the scientific at the expense of the artistic. Until we are able to change the medical school curriculum to give equal attention to these issues, we will have little success in addressing this process. We need to insure that communication skills, understanding of relationships, continuity of care, and the other staples of primary care medical practice are given equal billing with the more traditional biomedical sciences in the training of future generations of physicians.

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