Six Behavioral Scientists in Search of a Doctor: Family Medicine as Tragicomedy

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The dilemma of role integration between family physicians and behavioral scientists has been considered from a variety of perspectives. This article chooses to explore aspects of this relationship metaphorically through reference to a dramatic play, Six Characters in Search of an Author, *by the expressionist playwright, Luigi Pirandello. Using Schutz's FIRO-B model, which provides an analytical framework for understanding both social and professional relations, this approach illuminates issues of identity, belonging, territoriality, control, creativity, and team-building, which form the dynamic core of interactions between physician and behavioral scientist. This material was originally presented as an enacted dialogue at the Fourteenth Annual Forum of the Behavioral Sciences in Family Medicine, September, 1993.*

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THE relationship between family physicians and behavioral scientists remains a perennial challenge (20, 23). We would like to explore aspects of this relationship through a narrative metaphor, the dramatic play, *Six Characters in Search of an Author* (12, pp. 211–276), written in 1922 by the expressionist Luigi Pirandello. Much as been written about the role of narrative in understanding physician-patient relationships (3, 5, 18), but this approach has rarely been applied to an analysis of professional relationships within the discipline itself. Narrative, however, especially in dramatic form, may be useful in this context because it excels at illuminating issues of identity, power, and intimacy, all three of which are crucial to untangling the relationship between physician and behavioral scientist. *Six Characters* is categorized by literary critics as tragicomedy, but we hope that this exploration will elicit more optimism than bathos. A brief summary of the play follows:

> *Six Characters* is a play within a play. Six characters, created by an author who no longer wishes to have anything to do with them, are looking for a stage on which to come to life. They stumble upon a provincial stage manager and a troupe of actors going about their business of rehearsing another play by the playwright Pirandello, a play that they all intensely dislike. The six characters belong to a traditional, bourgeois drama about a wealthy, high-status husband who marries an ordinary woman, has a son by her, then casts her off. This woman, designated as the Mother, takes up with another man, has a

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daughter and then two other children with him, and suffers poverty and hardship. Eventually she is reduced to taking in sewing, while her oldest daughter secretly doubles as a prostitute. The Father rediscovers the family and takes them in, attempting to reunite them all. But to no avail: estrangement, cynicism, resentment, death, and suicide are the result. Results are no happier in the larger play. The characters cannot communicate adequately with the actors, who find the characters ignorant about dramatic training, arrogant, intrusive, and impossible to understand since they speak in an incomprehensible, philosophical jargon. When the characters see the actors' attempts to portray them, they are horrified—this is not what they are like at all! The play ends in chaos, both sides disillusioned and unfulfilled.

We will consider relationships between family physician and behavioral scientist, and between characters in Pirandello's play, using Schutz's FIRO model (15) because it provides a conceptual framework based on three constructs—inclusion, control, and intimacy—to describe the development of various social systems, whether dramatic or medical (see Figure 1). Inclusion, an In-Out dimension, refers to such issues as identity, role, belonging, and boundaries. Control, a Top-Bottom construct, examines questions of influence, power, and conflict. Intimacy, an Open-Closed continuum, represents the temporary resolution of the previous two phases, and focuses on producing team-building and working relationships through structures that emphasize connectedness, trust, and shared values.

The FIRO is a developmental model. It asserts that in the *early phases* of any organization, institution, or social system, or whenever a *new member* (such as a new character or a recently hired behavioral scientist) is introduced into the system, or whenever a *crisis* occurs within the system, issues of inclusion and control will have to be addressed and either resolved or stalemated. The FIRO model has been applied to family systems (4), especially within the context of family medicine as

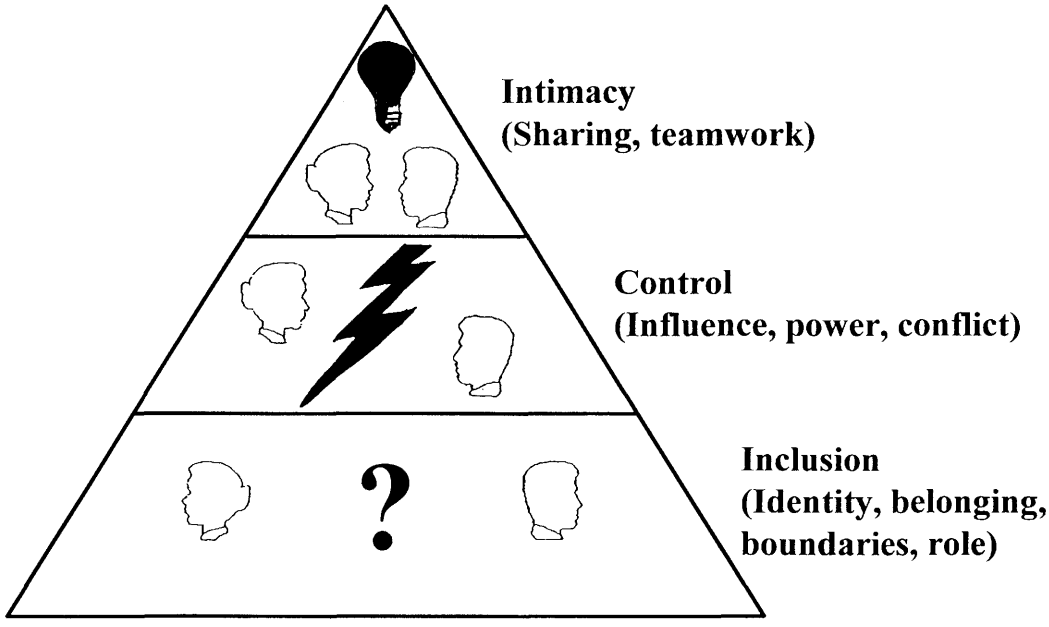

FIG. 1. The FIRO model.

well as to issues of birth (11) and death (6), and has proved itself to be a useful tool of analysis. Whether talking about family systems, practice systems (such as family medicine), or literary systems (such as a fictional drama), inherent in this model is the implication that no resolution is ever final, and that the nature of the resolution may look and feel very different depending on specific circumstances (10).

Inclusion

Identity: The first issue the FIRO model examines is inclusion, including identity, belonging, and boundaries. In *Six Characters,* the quest for identity defines the dramatic tension of Pirandello's play. The actors have no substance with which to fill themselves, while the characters have identity but no way to express it. This same search for identity characterizes behavioral scientists as well, who have been struggling to establish a secure role ever since they became associated with the specialty of family medicine (17). Because the physicians who invited behavioral scientists into family medicine were able to provide them a name but not a substantive role, identity became a chronic problem for nonphysicians in this setting. In Pirandello's play, the audience is forced to ask, "Who are real—the actors or the characters—and who are illusions?" One might ask a similar question in family medicine: "Who are these behavioral scientists and what are they really supposed to do?" and, even more pressing, "Whose reality is most important, the family physician's or behavioral scientist's, and how do these realities fit together?"

One might suppose that after so many years of association these questions would have been firmly and completely answered (13). One might simply assert that behavioral scientists are nonphysicians, with psychosocial expertise in a specific area, who are responsible for teaching residents and medical students about the connections between social science research and practice and medicine. But identity depends not so much on definition as on purpose, belonging, and a sense of ownership. Often, the honest behavioral scientist must ask whether what he or she is doing makes sense, fits, or has any utility for the learners who are the nominal recipients of this training. As has been frequently observed, we remain stuck in a "transitional" application of the biopyschosocial model (1), typically more talk than action, as true change is resisted by multiple homeostatic forces within the larger system of medicine. In this situation, while rhetoric and idiosyncratic experience support a role for behavioral scientists, the implementation of this role often becomes more peripheral and questionable.

Pirandello's play raises the intriguing possibility that the full expression of identity is an interdependent phenomenon: both actors and characters are incomplete on their own (22). A potential parallel exists for behavioral scientists and family physicians. In a professional vacuum, without the context of family medicine, the behavioral scientist clearly functions in a chronic state of incompleteness. This is because the full expression of the behavioral scientist's skills and abilities requires a partnership with the skills and abilities of family physicians. But it is possible that family physicians also rely in some respects on behavioral science input for full completion of their identity. Indeed, this interdisciplinary collaboration originally came into being only because family physician educators intuited that, from an educational perspective, something more complete existed than they were able to create in their curricula. They hoped that nonphysicians could somehow articulate more clearly the relational, practice part of their own specialty that they were not able to express didactically, but

that they experienced at every turn in the practice of medicine.

Of course, as in Pirandello's play, the tragic illusion in both cases was that a full-blown identity existed, waiting to be discovered. Physicians thought it would be self-evident to behavioral scientists exactly what they should and should not do. Behavioral scientists assumed from external appearances that a role existed for them ready-made, and if they couldn't figure it out, they somehow had failed. To fill the vacuum, at times they attempted to apply their area of specialty (whether family therapy or sociological analysis) without sufficient adaptation to the exigencies of a medical practice setting (2). These efforts to compartmentalize content, or attach it unchanged to traditional biomedical education, led to constricted, truncated identities. Similarly, when Pirandello's actors try to absorb the characters without paying attention to their evolving individuality, the result is a charade and a mockery.

In Pirandello's play, the concept of interdependent identity is suggested but never fulfilled. Both actors and characters remain incompletely realized. In family medicine as well, we have seen how limitations placed on the expression of identity can degenerate into stereotypic and shallow roles. Because their role is not consistently useful or significant, behavioral scientists may end up carping from the sidelines, complaining about victimization, or struggling for power with those perceived as more influential. In Pirandello's play, both characters and actors are undone by vacillations between narcissism and vulnerability. These mood swings are not unknown to behavioral scientists, and often express a deeply ambivalent sense of identity. At one moment, we insist that our way is the only way; the next moment, we are devastated by our peripherality and marginality. This sense of discouragement and disillusion often becomes expressed through dysfunctional resident behavior as well, in classical examples of triangulation and detouring.

Paralleling Pirandello's play, we must ask, "How is identity established? Can one person create it for another?" Were behavioral scientists somehow created, or brought to life by physicians; are physicians in some sense the authors of behavioral scientists? In fact, a partial answer to these questions may be, yes. Yet, as Pirandello noted repeatedly (7), an author may summon a character, but once called, the character is uncontrollable, with a life and purpose of his or her own that longs to be expressed. It is exactly this unpredictable expression of the behavioral scientist's identity that needs to be given freer rein in family medicine.

Belonging: According to the FIRO model, a second component of inclusion is belonging. *Six Characters* raises the question: "Who are permanent players and who are temporary? Who matters and who does not?" A "belonging" question in family medicine might be: "Who defines the core of the specialty, and who is simply passing through?" Questions such as these speak directly to problematic aspects of belonging. Despite the long association of family physicians and behavioral scientists, it is not clear that the latter are more than invited guests in the territory of the former. Whenever ugly budgetary considerations arise, it is apparent that nonphysicians are highly vulnerable. Similarly, arguments have been made suggesting that behavioral scientists are little more than transitional objects in family medicine, to be replaced by trained physicians at the appropriate time.

At its worst, for behavioral scientists, this situation may sometimes make them feel like the foreign guest laborers of Germany, brought in to do jobs that no one else wants or has time for, but who can

never earn the opportunity to vote, to become a citizen or to participate in the power structure and decision-making levels of the country. This pattern of disenfranchisement may persist for several generations. When behavioral science tasks are regarded as confusing, indefinite, and uncertain, distractions that encumber the streamlining of family medicine, the unfortunate taint of guest laborer is imparted to the role. A clear, valued role contributes to a sense of belonging. Marginality and ambiguity create an impression of temporariness.

Boundaries: The third aspect of inclusion has to do with boundaries. One cannot have boundaries without territory or, in our literary analogy, a stage on which the dramatic action occurs. While Pirandello's characters have a certain dramatic autonomy, they need a stage, and actors, to enliven them. Similarly, the behavioral scientist, who may have started out professionally as a psychologist, family therapist, sociologist, or anthropologist, has developed an essence discrete and separate from these former selves, which can be expressed only on the stage of family medicine. But territory implies ownership. Boundaries can either include or exclude, disenfranchise or clarify. At times in family medicine, the ownership of the "stage" is questionable, and whether behavioral scientists exist within or outside the perimeter is in doubt (8).

Control

The second dimension of the FIRO model is control. Control is often understood in hierarchical terms, with the implication that there must always be an agent of control and an object of control (16). In this sense, control is closely related to the concept of power over another. Too often in medicine, control is defined through this hierarchical mode, all the way from patient care to resident teaching to departmental functioning (14). But Pirandello's play hints at the existence of a different kind of control, an interdependent control, which acknowledges the needs of all participants in the system to exert influence, be heard, and at the same time develop viable methods of cooperation and compromise.

In Pirandello's play, the question arises as to who controls the action on the stage. Where does the power reside? On the one hand, the six characters come almost as supplicants, begging for a chance at self-expression. From a hierarchical perspective, the stage manager appears to have all the control and to determine the outcome. But we soon realize that the true locus of power is more indefinite and fluid. The stage manager provides order and direction; the actors contribute their skill and training; and the presence of the characters enlivens and inspires the proceedings. Control is not located in one or another, but emerges as the result of the interactions of all the participants.

How do control and power themes operate in family medicine between physicians and behavioral scientists? Who has decisional authority? Who exercises fiscal control? In family medicine, as in other spheres, power is intimately related to inclusionary concerns, to a well-established sense of identity and a secure feeling of belonging. In the absence of inclusion and belonging, power becomes a hierarchical, win-lose situation. Behavioral scientists who feel respected and valued, who feel they have a reasonable degree of control over their professional lives, will experience themselves as competent and capable. It is only when departmental and specialty control issues are resolved that both physicians and behavioral scientists can take professional risks and behave in creative, innovative ways without fear of censure or punishment.

Intimacy

According to Schutz's model, it is only by addressing issues of inclusion and control that organizations and systems can achieve a (temporary) intimacy, which translates organizationally as productivity, creativity, and team-building. The dramatic action in *Six Characters* is not really about the characters' apparent grievances, injustices, and hurts, just as the core of family medicine has little to do with the perceived slights suffered by behavioral scientists. As Pirandello states, this is traditional theater, overworked and somewhat boring. He is trying to say something more profound about the synergistic effort of creation, in which the characters are dependent on stage manager and actors to reach true fulfillment, and where the actors need to be inspirited and enlivened by the stories of the characters. This type of intimacy is precisely the sort of vision we seek to realize in family medicine between physicians and behavioral scientists.

What happens in Pirandello's play is discouraging. It is filled with the imagery of rejection, betrayal, and abandonment. The characters reject the actors and vice versa. In the play within a play, Father betrays Daughter, Brother rejects Sister. Rejection, miscommunication, and misunderstandings are familiar dead-ends in the interactions between behavioral scientists and family physicians. In this sense, Pirandello sounds a cautionary note by providing a map of a self-preoccupied, antagonist terrain that we in family medicine would do well to avoid.

In the tragicomedy of family medicine, we may imagine a happier ending. The alternative to rejection is acceptance and reconciliation. As Pirandello points out, a successful play depends on balance, on everyone playing a part. A good director also realizes that plays are always works in progress, that they cannot simply spring to life full-blown, but must evolve in space and time. This suggests that a certain amount of initial confusion and conflict are the inevitable result of family medicine's pioneering interdisciplinary vision uniting behavioral scientists with family physicians. It takes time, trust, and creativity to resolve issues of inclusion and power, and to achieve a truly intimate relationship. To some degree, this intimacy has already been achieved over the past 20 years. What can we do to encourage its continued survival?

Recognition of a Shared Project

Our goal as behavioral scientists and family physicians is to function as a team. But there is no team without a common project. In Pirandello's play, both actors and characters have lost sight of their common project, which is to stimulate and bring pleasure to the audience. In family medicine, our projects are well-defined and engender widespread agreement among both family physicians and behavioral scientists. We all endorse promoting the health and well-being of our patients, and the teaching of future family doctors. Whatever else may be a source of disagreement and acrimony among family physicians and behavioral scientists, on these we can concur. By keeping our shared goals in mind, it becomes easier to address other more problematic issues.

Communication

We must reexamine the tired truism of communication, and admit after all these years, that behavioral scientists and family physicians still do not always understand each other very well. Communication is the skill that allows us to negotiate the three stages of Schutz's model. Often what interferes with true communication is the recollection of past misunderstandings, and an atmosphere of automatic listening. The noise of physicians' assumptions about

psychologists, and vice versa, may drown out any true listening. Perhaps we do not sit down with our colleagues often enough to share our innermost thoughts because we are secretly afraid our paths may lead in different directions. But it is precisely this sort of constructivist, evolving dialogue that is required to enliven family medicine and prevent it from degenerating into a specialty whose function is primarily that of economic gatekeeper. The goal of communication is not always to eliminate different understandings, but to smooth their rough edges and insure their usefulness. Closure on any issue guarantees stagnation. Rather, we need to cultivate and nurture our creative differences through dialogue. Trust is the merging byproduct of many such honest and searching conversations.

Relational Nature of Family Medicine

We must persistently keep before us the essentially relational nature of family medicine. The essence of this specialty is not specifically in its family orientation, or its cost-effective potential, or in its breadth of patient care, but in its ability to conceptualize the practice of medicine as an interactional process involving the viewpoints, priorities, needs, and fears of many people (19). The dynamic tension, the inevitable conflicts that result from this interaction should be viewed not merely as problems to be overcome, but as a necessary and valuable part of the discovery process required by the evolving nature of the discipline. This is as true of the relationship between behavioral scientist and physician as it is for the relationship between doctor and patient.

New Identities

Out of these process efforts must come an evolution of new identities for both family physicians and behavioral scientists. One example of this is the concept of a medical family therapist, pioneered by Susan McDaniel and colleagues (9), which begins to define a unique behavioral scientist identity that has its roots in family medicine as much as in psychology and family therapy.

But there is a danger of seeing such proposals as an endpoint, a permanent solution rather than as merely one of an infinite number of model possibilities, some realized, some perhaps not even conceptualized (see Figure 2). There may be medical family therapists, but there may also be family medical therapists, old-style behavioral scientists, physician behavioral scientists, and other offspring as yet unimagined. Our conviction is that the issue of role identity for behavioral scientists and family physicians can never be solved once and for all. Rather, each time new challenges arise, such as managed health care or the recent ascendancy of family medicine on the national health care scene, issues of identity and collaboration must be reworked and reconstructed.

This recognition leads in turn to an acknowledgment of the mutuality of purpose and function for behavioral scientist and family physician. Mutuality depends on a shared sense of power, a fluid locus of control, and an equal burden of responsibility. For these goals to be met, we must be prepared to modify our approaches to resident training and patient care, and include behavioral scientists as equal partners in each, although with distinctive spheres of influence and expertise.

Belonging and Boundaries

In this regard, we must redefine professional territory not as a boundary to be defended, but as a resource to be shared. As long as behavioral scientists are considered in some sense as guest laborers, issues of belonging will never be resolved. Family medicine will be the loser because the field will be deprived of the full energy and

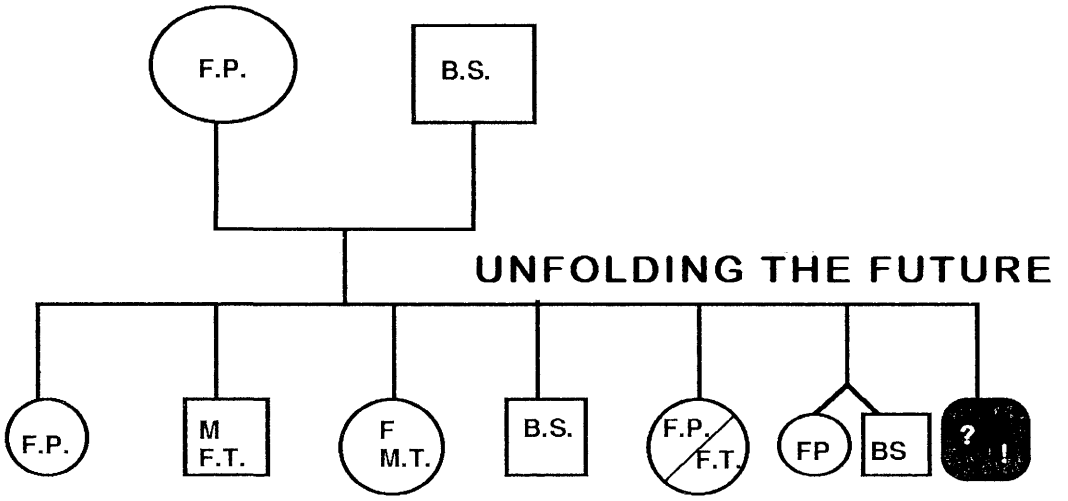

FIG. 2. Possibilities for evolving roles of family physicians and behavioral scientists.

commitment of its nonphysician members. By making the concept of ownership more fluid, behavioral scientists are afforded the opportunity to become full stakeholders in family medicine.

Perhaps what is needed is a context in which to probe new identities, a recognition of the "family" in family medicine. High-functioning families are essentially in the business of promoting belonging and inclusion. However, another of the attributes that characterizes healthy families (as well as social and biological systems) is that they are able to tolerate, and even encourage, a wide range of diversity. Being a behavioral scientist probably will always carry with it an inherent element of conflict, a sense of not quite belonging (21). In some form or other, behavioral scientists in family medicine will always be asked to "hold" and deal with problematic aspects of the profession (for example, the subjective, the experiential, the difficult-to-measure). But the ambiguity of the position becomes significantly easier if it is enclosed in the circle of "family," if a consensus exists that roles of both member and member-as-outsider can be contained within the family's structure.

A Process Vision

Both behavioral scientists and family physicians must be willing to surrender cherished assumptions about how the profession of family medicine "should" look. A practice profession like family medicine also has a life of its own, as it is daily constructed in the unique and surprising interactions between patients and doctors, teachers and learners, behavioral scientists and family physicians. To the extent that we resist recognizing this truth, and attempt to force static visions on a dynamic field, we will limit our own relevance. Although the characters and actors approached each other with initial enthusiasm in Pirandello's play, they soon became disillusioned. Behavioral scientists and family physicians cannot allow their unique collaboration to degenerate into this type of chaos and cynicism. We must continue to listen to and learn from each other, and make choices that enhance the potential of our creative interdependency.

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