

## Applying the Concept of the Reflective Practitioner to Understanding and Teaching Family Medicine

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### ABSTRACT

*This article contends that what makes family practice unique as a medical specialty is not so much its content (eg, continuity of care, broad range of patient population) as it is the process of clinical practice (ie, how the specialty is actually practiced in ongoing patient encounters). However, insufficient attention has been paid to critically analyzing and interpreting this process. We present a model derived from other "practice professions," such as architecture, known as reflection-in-action. This model is offered as a way of first apprehending and subsequently teaching the "professional artistry" which constitutes a critical component of family practice. Specific teaching approaches designed to enhance reflective medical practice are delineated.*

(Fam Med 1991; 23:450-6)

That family practice has facets which are both unique and distinct from other primary care specialties is an assertion which has been widely debated.<sup>1,2</sup> The contention of this article is that, in fact, family practice deserves to be understood as a distinct specialty. We shall argue that the uniqueness of family practice is found not so much in the content of the specialty (ie, competency-based mastery of specific procedures, broad range of patient population) as in the process of the specialty (ie, how the specialty is actually practiced): how family doctors think about, interact with, and make decisions about their patients.

This intangible relational essence of what it means to be a family doctor has been the focus of much theorizing.<sup>3,4</sup> Most educators in family medicine would agree it is an essence which needs to be transmitted to succeeding generations of family physicians. But while it is, relatively speaking, a straightforward matter to teach colposcopy, it is less easy to teach an "essence."

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It is also our belief that, although the process of clinical practice in fact lies at the core of family practice's uniqueness, insufficient attention has been paid to critically and systematically analyzing and comprehending this process. Thus, we will present a model which we feel can be helpful in making explicit certain of the process assumptions and values which underlie the practice of family medicine.

### Family Practice As a Practice Profession

In considering how the process of family practice can best be identified and transmitted, it is important to recognize that family practice, like other clinical medicine specialties, is at heart a practice profession.<sup>5</sup> Practice professions have been defined as having a "strong real-world applicability component," in which the vast majority of one's professional activities are not addressed adequately either by textbook learning or research findings. Such practice professions are obviously not restricted to medicine, but include architecture, education, and psychotherapy. A practice profession is one in which there commonly exists a gap, at times a gaping chasm, between espoused or advocated theory and actual theory in practice.

Characteristic of practice professions is that they often have difficulty successfully locating the core of their professional identity because the nature of the profession is continually being co-created as a joint process between the practitioners and those "practiced upon." Thus, it is only inquiry into process which will truly capture the unique aspects of any given profession's "practice."

### Specific Characteristics

As stated above, all clinical medicine specialties are practice professions. What distinguishes family practice from primary care pediatrics or general internal medicine is the unique way in which its practice manifests itself.

There are several process characteristics which may be said to compose the core essence of family practice.

1. Family practice is a "science of particulars,"<sup>6</sup> which expresses itself most truly in attending to the unique and idiosyncratic experience of each individual patient. As Howard Stein has observed,<sup>7</sup> "It is as if medicine is created anew with each patient encounter . . . The truth of the matter is that we never know

- beforehand what it is that we need to know or look for or hear, let alone do.”
2. A corollary to this observation is that family practice is context focused<sup>8</sup> and makes use of generalizable principles only as mediated by the particular context.
  3. Family practice is fundamentally relational, in that it does not consist of agent and object “acted upon,” but rather requires the mutual construction of trust and problem solving between doctor and patient. Although it was Eric Erickson who first propounded the principle of mutuality between healer and patient,<sup>9</sup> this has become an important tenet of family practice as well.<sup>10</sup>
  4. Further, family practice relies heavily on a discovery-oriented inquiry process.<sup>11</sup> The intent of this approach includes an openness to what is “out of the ordinary, exceptional, challenging, disconcerting; what doesn’t fit . . . and is hard to grasp, organize, or explain.”
  5. The true forte of family practice lies in its potential to skillfully address itself to “ill-structured” problems. Ill-structured problems are those in which the “initial and final system states are not clearly apprehended, and in which the number of possible solutions is so large that general methods of problem solving are likely to be unproductive.”<sup>12</sup> This definition does not share much in common with the diagnosis of a broken ankle, but it describes remarkably well the nature of psychosocial and family problems which impinge on a diagnosis of cancer, diabetes, or unwanted pregnancy.
  6. Finally, and perhaps most radically, the biopsychosocial assumptions<sup>13</sup> inherent in “care for the whole person” stand in potential opposition to the dominant biomedical paradigm.

### Philosophical Underpinnings

How we approach understanding and transmission of a practice profession depends in part on our philosophical assumptions, biases, and beliefs. In the post-Flexnerian era, medicine has been widely assumed to be a science.<sup>14</sup> In this view, clinical medicine is the necessary, although regrettably messy extension of the basic sciences, themselves rooted in an objectivist, empiricist view of the world<sup>18,15</sup> sometimes called technical rationality. According to this view, practitioners are expected to systematically apply theory and technique derived from rigorous scientific knowledge. It is assumed that they will always be able to make precise, logical connections between the presenting situation and a particular body of professional knowledge. Technical rationality perceives any given clinical reality to be singular and unitary, requiring only the application of appropriate facts to be comprehended. Technical rationality supports and is consistent with the biomedical paradigm.

However, from a philosophical perspective, other views of reality exist, perhaps more relevant to the practice of family medicine. In the constructionist view,<sup>16</sup> for example, clinical practice is regarded as indeterminate, ambiguous, uncertain, unique. Practitioners become “worldmakers”<sup>17</sup> who, in conjunction with the contribu-

tions of those practiced upon, create a range of simultaneously coexisting realities. According to this view, solutions are not simply applied but mutually constructed. As a consequence, “truth” or clinical reality is no longer unilateral but mutual, negotiated, and open to multiple interpretations.<sup>18</sup> This mutual “worldmaking” is at least as much the province of the artist as the scientist: in constructionist terms, “the competence by which practitioners actually handle the indeterminate zones of practice,”<sup>19</sup> the ill-structured problems, professional artistry, or craft.<sup>20</sup> Such a view is more compatible with a biopsychosocial model of health and illness.

### Methods of Analysis: Reconstructed versus Authentic Modes

One of the fundamental issues continuing to face academic family medicine may be stated as follows: How do experienced clinicians best analyze and understand what they do? Clearly, many different approaches to ascertain this understanding are required. In part, the approach selected is determined by the type of material to be analyzed. Material which is discrete, unambiguous, and does not challenge prevailing foundational assumptions of the profession may be analyzed and understood in a “reconstructed” manner.<sup>21</sup>

In this method of analysis, exemplars retrospectively “reconstruct” their problem-solving skills and techniques. Such reconstructions are generally theoretically and/or empirically based. They look efficient, elegant, and tend to be highly generalizable. But at times such reconstructed methods of reasoning do not seem to be relevant to the less-experienced practitioners who attempt to apply them.<sup>22</sup> This seems to be the case particularly in situations where the body of knowledge to be understood is complex, characterized by ill-structured problems, open to multiple understandings, and challenges the prevailing paradigm of the learner.

In the diagnosis and treatment of illness from a family practice perspective, inevitably there exist multiple simultaneous interpretations, idiosyncratic meanings, conflictual and complementary assumptions, all deriving from the context and relationship of physician and patient.<sup>23</sup> In such situations, reconstructed methods fail us because they have no means of helping us understand the richness, subtlety, complexity, and uniqueness of what confronts us. Further, the decision-making processes compelled by such situations are rarely based completely on rational, scientific, objective factors, which reconstructed methods could successfully access.<sup>24</sup> Other more unconscious motivations, such as family of origin issues<sup>25</sup> or anxiety alleviation,<sup>26</sup> consistently come into play.

Thus it becomes essential to understand “how decision-makers *frame* the decision problem.”<sup>27</sup> In this case, there may be a distinction between formal models, which describe how a physician should think, and interpretive models, which help us understand how physicians actually do think. Thus, we must search for more “authentic” accounts of the means by which expertise is implemented, methods of analysis which are fluid and flexible, and which use paradigms designed to suit particular circumstances rather than general principles.

The paradox of practice expertise is that the greater experience and skill practitioners have, the less able they are to articulate what it is they are doing.<sup>28</sup> In the practice of family medicine, two types of knowledge are relevant. Expressed knowledge, the kind of technical information and skills involved in the solution of routine problems and tasks, is easily accessible and analyzable. Displayed knowledge, on the other hand, involves what in learning theory is referred to as "automaticity,"<sup>21</sup> or the accumulation of relational information which has been overpracticed to the point where it can be exercised without thinking. Reconstructed methods of recreating this process are ineffective precisely because of their strengths--they are too simplistic, linear, logical, and error-free. They do not adequately replicate the imperfect process whereby real-world solutions to ambiguous, ill-structured problems are achieved.

Authentic modes of reasoning, which have been proposed in contrast to reconstructed modes, are developed by those who practice them and are validated by evidence "demonstrating that they are operative in the behavior of the members of a problem-solving community."<sup>21</sup> They are descriptions of problem-solving approaches which are situational, constructed moment by moment, and continually adjusted and revised. Authentic methodologies for studying the practice of a particular profession include process tracing,<sup>29</sup> ethnographic studies, micro-analysis through audio and videotape, and clinical case studies.

One of the most illuminating studies of applying authentic methodology to medical practice was Kassirer and Gorry's classic behavioral analysis of clinical reasoning.<sup>30</sup> In this medical role-playing situation, a variety of clinicians provided a running commentary on their decision-making processes in reaching a diagnosis of a simulated patient. The study illustrated that while all clinicians used the same basic strategies for evaluating hypotheses and collecting information, they engaged in noticeably distinct decision-making styles, ranging from a hit-and-run approach, to strategies to uncover a unifying core, to historical, chronological data gathering. More recently, a study by Gerritsma and Smal<sup>31</sup> distinguished between the cascade method of hypothesis favored by family physicians and general internists' reliance on the "screening of data strategy," again providing evidence of substantial process differences among primary care specialists. In searching for explanations of these and similar findings, Bowman speculates that "family physicians could be better at choosing the *process* that is pertinent to the individual patient and situation."<sup>32</sup>

Other researchers have used the interpersonal process recall approach<sup>33</sup> (the use of immediate video feedback subsequent to the doctor-patient encounter) to elicit previously unrecognized feelings in the learner,<sup>34</sup> such as the fear of losing control of the interview or anxieties about causing harm to the patient. This approach may be considered authentic because of its immediacy, because of its step-by-step analysis of process, and because it actively encourages consideration of the experience from a new vantage point (ie, that of the resident), a perspective normally considered peripheral or irrelevant in the dominant biomedical model.

One authentic method for probing clinical process has been propounded by Donald Schon, who has made a career of studying a range of practice professions. Schon's work describes an authentic method of process analysis which results in the development of a "reflective practitioner."<sup>19</sup>

### Understanding the Reflective Practitioner

The primary characteristic of professional artistry or practice, as Schon has defined it, is "knowing-in-action," or the spontaneous, skillful execution of performance in a live situation. Knowing-in-action gives rise to clinical behaviors which leave less-skilled observers at once impressed and mystified. Knowing-in-action is based on tacit or displayed knowledge,<sup>28</sup> that which we know but have difficulty articulating. At a simple level of behavior, knowing-in-action may be illustrated by our ability to ride a bicycle. At a more complex level, knowing-in-action determines many of the moment-by-moment microdecisions which comprise the bulk of clinical practice.

Reflection-in-action is a key component of knowing-in-action and refers to the process called into play when the bicycle skids. At this moment, a surprise or an ill-structured problem has arisen for the rider of the bicycle. While in the process of acting, the rider is simultaneously working to respond appropriately to this unexpected development. The rider may be noting fear and confusion as evidence that something untoward is occurring; he or she may be comparing this situation with past riding episodes; he or she may be testing out various responses and, based on the feedback from the bicycle, altering and modifying them.

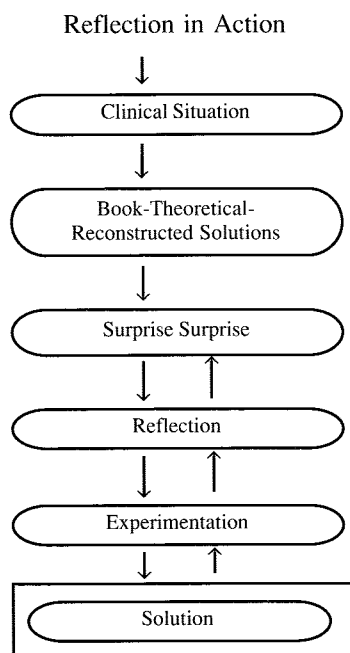
Reflection-in-action, like knowing-in-action, is usually a subliminal process of which the actor is only partially, if at all aware. The issue is not how to make it occur but how to give the learner the most control possible over this process and to ensure that its outcomes have the maximal therapeutic relevance for the patient. The study of reflection-in-action has as its focus the goal of making tacit knowledge explicit and thereby more easily understood and worked with.

### How Reflection-in-Action Works

The starting point of practice learning in medicine is the clinical situation. Usually, the clinical situation will contain a problem for which the physician-in-training turns to theory, research, and exemplars' reconstructed methods for solution. However, the idiosyncratic properties of this particular clinical situation may present certain unexpected or surprise elements that represent a significant deviation from or complication to the analog situation described in the textbook.

The learner has two choices. The learner may ignore the surprise presented by the clinical situation and attempt to treat the problem as if it actually conforms to the general principle with which he or she is familiar. However, this approach usually will result in flawed clinical choices. The second approach advocates skilled reflection during the course of action on the part of the learner in response to the surprise, ie, the unique, ill-structured dimensions of the clinical problem. Reflection in the

Figure 1



Adapted from D. Schon and C. Argyris.<sup>19</sup>

presence of action will lead to hypothesis formation, experimentation, feedback, reframing, and eventually the “design” of a tentative solution (Figure 1). Reflection-in-action produces on-the-spot experimentation and improvisation, in which the surprise data being presented are weighed in conjunction with past theoretical knowledge, previous clinical experience, other relevant information (ie, the patient’s psychosocial history), the learner’s own personal history, both the patient’s and physician’s emotional reactions to the current situation--and a response is produced.

Reflection-in-action by definition requires a patient-centered approach to medical care. There have been many calls for a patient-centered approach in family practice. But efforts to quantify and systematize this approach,<sup>36,37</sup> while having a certain utility, may in the long run prove incomplete. Although the identification of general principles and rules provides a certain helpful orientation for the learner, they may be insufficient for truly comprehending the patient’s agenda: the feelings, expectations, and fears which are brought to the experience of illness. By contrast, the feedback elicited from the patient to this reflective process of hypothesis formation and experimentation will lead to further restructuring strategies, changes in both the physician’s and the patient’s understanding of the phenomenon under investigation and additional alterations in terms of framing the immediate problem. This continual give and take between physician and patient leads to a negotiated reality in which the understanding of and response to the problem are mutually constructed.

Table 1

Models I and II

Model I	Model II
<ul style="list-style-type: none"> <li>• Win and avoid losing</li> <li>• Achieve your objective</li> <li>• Avoid negative feeling/feedback</li> <li>• Be rational</li> <li>• Maintain unilateral control</li> <li>• Unilateral protection of self and others</li> <li>• Closed defensive</li> <li>• Task oriented</li> <li>• Incongruity between theories</li> </ul>	<ul style="list-style-type: none"> <li>• People can exchange information</li> <li>• Mutual control</li> <li>• Bilateral protection of self</li> <li>• Open, high risk taking</li> <li>• Constant feedback (pos/neg)</li> <li>• Clarification of assumptions</li> <li>• Congruity of theories</li> <li>• Process oriented</li> </ul>

This ongoing process of “design” of the interaction, or “frame experimentation,” Schon argues, is very different from random trial and error. To be effective, such designing pays close attention to the “backtalk” (the feedback, consequences) produced by each shift in behavior. Thus, reflection-in-action becomes at once a creative and analytic ongoing invention of new trials based on an appreciation and evaluation of the results of earlier trials. It is an opportunity for the physician to continually and subtly reshape what is being done with the patient while in the process of doing it.

Teaching the Process of Family Medicine: Model I

For Schon, in his study of practice professions, teaching becomes the central dilemma. The question he poses is how or whether one can transmit practice knowledge that is relativist, constructionist, and particularistic in nature. Is this critical process core of a given discipline truly accessible and communicable?<sup>38</sup>

Schon identifies two modes of interaction which occur in learning situations<sup>19</sup> (Table 1). The first he labels Model I, which is characterized by a strong need to win and avoid losing. This model emphasizes achieving one’s objectives, avoiding (or refusing to acknowledge) negative feelings or feedback, exclusive reliance on rationalism and logic, maintaining control of situations, and engaging in unilateral self- (and at times, other) protective strategies. It is a mode which is fundamentally closed, defensive, and exclusively focused on the content of the task.

What is of concern in Model I teaching is the large gap that may develop between performance in a teaching situation and action in an actual clinical encounter. For example, an ingenious study by Wolf et al<sup>39</sup> illustrated that a psychosocial intervention could significantly increase students’ preferences for responding in an empathic way to patients and indeed could increase students’ written behavior of empathic responses. What remains uncertain in a design of this nature is whether students actually behave with more empathy and compassion in clinical interactions with patients.

In medical education, much of the emphasis remains on content mastery, rather than the process by which the learner achieves that mastery. Clinical reasoning, problem solving, and decision making are still not adequately recognized as learner goals.<sup>40</sup> Thus, for example, decisions often are made by teams regarding a patient's status and management, without any attention paid to the process by which such decisions were reached.<sup>41</sup>

Reconstructed methods lend themselves easily to this dominant pedagogical approach, which prides itself on providing efficient, effective models and interventions; concise, specific goals and objectives; and skill-oriented, step-by-step learning procedures. As D.M. Smith, a student of Schon's, observes, theoretically, according to this model, "If the material is skill based and clearly articulated, if learners can learn about the material in theory, see it modeled by an expert, and rehearse skills in progressive stages, then the learners should acquire the new skills."<sup>42</sup>

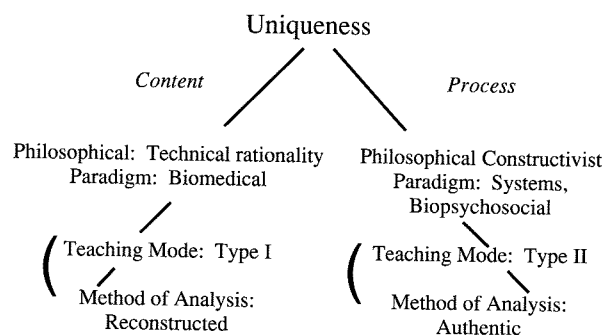
#### *A Case in Point: The Family in Family Medicine*

In an effort to locate the core identity of family medicine, many academicians in the preceding decade focused on the family-oriented approach to patient care as a unique way of defining the specialty from a biopsychosocial perspective. Yet despite some success in these efforts, research has documented that programs designed to teach family therapy to family physicians, although well designed and implemented and received with enthusiasm, result in significantly modified and haphazard modes of usage. "Physicians were inconsistent, incomplete (although not illogical) . . . idiosyncratic and individualistic in their application of concepts and techniques."<sup>43</sup> Perhaps whatever went wrong with such efforts to teach family-oriented medicine went wrong in part because of the underlying assumptions on which such educational effort was based.<sup>44,45</sup>

For example, it often was assumed that content knowledge about families (family therapy, family life cycle) was the key element to creating more competent family physicians and that if residents mastered this content (theoretical concepts, specific skills and techniques), they would be transformed into better family physicians. Secondly, it was widely assumed that "experts" on family (eg, behavioral scientists, family therapists) would be in a better position to impart this specialized knowledge than would be the "generalists" (family physicians) already in place. Third, it was taken for granted that teaching about family represented a discrete, identifiable body of knowledge which could be systematically and rigorously imparted to learners. Finally, the assumption was made that the problem of defining the core essence of family medicine could be solved by incorporation of additional facts and that this problem of professional identity would prove susceptible to a solution which was unitary, unambiguous, and externally imposed.

It is possible that, in the attempt to crystallize the troublesome issue of professional uniqueness, academic family medicine wrote the equation in reverse. Family medicine is not unique because it has expert knowledge about families. Rather, it deals with families (among other things) because of the nature of its unique process.<sup>46</sup>

Figure 2



Working with families does not define family practice's uniqueness as a practice profession. It is an outgrowth of the specialty's unique process and relationship characteristics.

#### **Teaching the Process of Family Medicine: Model II**

When traditional pedagogical models prove ineffective, as in the case of the family in family medicine, one must seek new teaching modalities. Model II teaching approaches, as described by Schon and Smith, enhance the development of a more receptive learning environment, emphasize the utility of authentic modes of analysis, and encourage learners to move among paradigms and even to create new ones.<sup>47</sup>

Model II teaching is an approach in which individuals can openly and freely exchange even sensitive information on many interpersonal levels. It is characterized by mutual control of the interaction, bilateral protection of self and other, openness, risk taking, continual feedback, and clarification of assumptions. It is process oriented rather than content oriented (Figure 2).

#### *Problems of Model I Teaching*

Schon points out that while most teachers claim to engage in Model II-type teaching, actual analysis of their behavior demonstrates that it is usually based on Model I premises. Unfortunately, teaching from a Model I perspective often results in a failed or inadequate teaching experience. Schon observes that when students feel vulnerable to threat, they produce "automatic intercepts," responses which block efforts at Model II behaviors. These intercepts are provoked primarily by fear of being or appearing incompetent. Thus, a resident who fears ridicule or exposure of ignorance (implications of Model I teaching) will cling tenaciously to Model I responses with a patient, although a more exploratory, improvisational approach might be more appropriate. When risk taking is seen as aversive or dangerous (again, implied by Model I teaching), the learner tends to sink into passivity, always taking the safest approach.

A style of teaching which avoids any kind of confrontation, which assumes the achievement of completeness or perfection on the part of the learner, which fails to invite

on-line challenge and correction, will not be conducive to transmitting a reflective approach to patient care. In such an adversarial relationship, the student may feel threatened by the master's expertise, while the master may feel the need to protect his or her artistry from the lack of skill of the learner. Student and teacher then tend to keep their thoughts and feelings private. The ideas that process should not be discussed and performance cannot be described are reinforced.

### *Specific Model II Teaching Approaches*

Joint experimentation is a term for the most obviously mutual and egalitarian teaching style. In this approach, there exists a process of collaborative inquiry between teacher and student, in which the teacher helps the learner formulate goals that the learner wishes to achieve. Together, teacher and student explore different ways of producing these goals. This process in turn is also influenced by the ongoing needs and feedback of the patient. However, for the teacher to facilitate the generation of a variety of solutions to the problem presenting itself, the student needs to be sufficiently sophisticated to be able to express what he or she wants to accomplish.

This is not always the case. In such circumstances, a more directive form of teaching may be necessary. Often, in the initial stages of learning, confusion and mystery reign. The meanings held by teacher and student are incongruent and mutually inaccessible. The teacher may need to adopt a follow-me technique in which, in response to the initial learning stimulus, a whole design-like performance is improvised. In this process, the student must be able to put individual goals into abeyance and simply try to follow the teacher, both in performance and in the subsequent reflection on the units of that performance. Although authoritative, such an approach can still be executed within the principles of Model II teaching, if the teacher can accept challenges to and modifications of the performance offered.

A final form of Model II education has been called by Schon "Hall of Mirrors," and relates to the essential isomorphism or parallelism which can occur between patient-resident and resident-faculty.<sup>48</sup> In this situation, the teacher takes advantage of the fact that the interaction with the student in some respects has become a reenactment of the student's own predicament in practice. This replication of process (for example, the resident's experience of a patient as hostile and resistant may be mirrored by the attending's assessment of the resident as characterized by precisely these same attributes) may provide an opportunity for modeling redesign of problematic aspects of practice. By correcting or adjusting the process between teacher and learner, the student learns by extension what must be done to succeed with the patient. Even here, of course, continual adjustments and modifications based on reflection-in-action are necessary, since the mirror approximates but does not duplicate the reality being created between student and patient.

Learning that evolves from a reflective, Model II, process-oriented approach will be characterized by substantive understanding, a holistic grasp of concepts, and be broad, deep, and flexible. Learners will use what they have comprehended to create, as necessary, new rules and

new interventions. By contrast, learning derived from Model I will be characterized by a closed-system vocabulary, in which learners simply parrot certain technical language to convey the illusion of comprehension, and in which learners rely on unitary procedures rather than comprehensive overview. Such learning will be at once narrow and superficial and will demonstrate the rigidity and overlearned responses of a true believer.

### **Surfacing Paradigmatic Conflict**

In situations where conflictual paradigms are operative--as in the case of the biomedical model, which underpins much of medical education, and the biopsychosocial model, which provides a more adequate framework for family medicine--the question arises as to how to navigate a shift in paradigms. Some authors make an assumption of continuous learning and expect that the gulf between paradigms can be traversed by gradual building on extant assumptions and awarenesses.<sup>49</sup> However, others maintain that when basic assumptions and values are challenged, learning is not continuous but becomes conflictual and discontinuous.<sup>47</sup>

It is at this point of conflict, or surprise, that Model II learning can be an extremely useful strategy. Most learning situations attempt to avoid, diffuse, or override potential conflict. Indeed, regardless of what paradigm one is operating from, teachers tend to demonstrate the validity of their own approach and structure information so that their assertions are proved right. In fact, we need an approach to help us understand what is actually happening in a given situation, as opposed to what our model tells us is happening. We need methods to help us understand what we do, as opposed to what we think we do. This type of learning has been referred to as generative, and uses model conflict as an impetus for reconsidering and modifying a given model's assumptions, values, and goals.<sup>47</sup> By designing impromptu experiments to gain insights into practice differences, new models are continually created. Such an approach requires the surfacing of conflict and ways of systematic exploration.

### **Conclusion**

In accessing and teaching the core practice of family medicine, we may have to rethink some of the assumptions we have made and some of the steps we have taken. It is the contention of this article that perhaps we have relied too heavily on a focus on content rather than on process, on philosophical assumptions of empiricism and technical rationality rather than on more particularistic, interpretive, and constructionist assumptions, on analytic methods favoring reconstructed rather than authentic modes of reasoning, and on pedagogical approaches typified by Model I rather than Model II characteristics.

What we must encourage in the future is our continuous coming together as family medicine educators, students, and patients in a reflective, mutual, constructivist exchange to address questions regarding the substance of practice. To resolve the dilemma of articulating a unique professional identity, we require an ontological process of collaboration, mutual dialogue, and joint experimentation in an attempt to unravel the world in which we find ourselves. Teaching about the family, for example, will

then emerge naturally from the continuous discovery and creation of the way in which "family" actually manifests itself through the process of clinical practice. Hopefully such reflective, collaborative self-study of the specialty can be extended not only toward the concept of family-oriented practice, but also to such challenges as family medicine research and the ethical implications of indigent care.<sup>50</sup> Such a process will help ensure that in seeking our identity we do not lose our soul.

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