# BEHAVIORAL SCIENCE REVISITED:

# THE ART AND THE SCIENCE

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**ABSTRACT**

Behavioral science continues to play an ambiguous, problematic, but key role in the training of family physicians. At this point in the history of family medicine, both dangers and opportunities await the upcoming generation of behavioral scientists. What are the truly unique contributions which behavioral science can make to family medicine? What are the educational and research priorities which behavioral science faculty should advocate and emphasize? In future decades, behavioral scientists must learn to respond to the technologic, rationalistic pressures of the traditional medical establishment, as well as to assume more active leadership roles in teaching and research. In particular, it is crucial for behavioral science faculty to conscientiously develop the relationship between behavioral science teaching and art of medicine issues, which have long been neglected in formal medical curricula. Continued examination and definition of the role of the behavioral scientist is essential in order to promote a truly collaborative and dynamic relationship between behavioral science and family medicine.

# Behavioral Science Revisited: The Art and the Science

## INTRODUCTION

Seven years ago I wrote an article[1] considering the obstacles and possibilities inherent in the integration of behavioral science and family medicine. Now, after almost ten years in the field of family medicine, I feel impelled to re-examine some of the themes and assumptions of that article, especially as they alluded to the pitfalls and possibilities existing today for behavioral scientists in family medicine. As a cautionary note, my thoughts and reactions regarding the role of behavioral science in family medicine today are completely idiosyncratic, perhaps quixotic, based only on my own experiences, observations, and needs. The role of behavioral scientist that I personally am increasingly moving toward is one I do not advocate as the only role for all behavioral scientists. However, it is a tradition, a dimension, perhaps even an ethical imperative[2] in family medicine which I believe must be acknowledged, respected, and preserved.

## DANGERS FOR BEHAVIORAL SCIENTISTS

As I reflect on ten years in family medicine, I am struck by both dangers and opportunities confronting behavioral scientists in this field. Let me context these thoughts by saying that I see my sojourn in family medicine as not dissimilar to the process of a therapist joining a family system (I am not implying in any sense that I was hired, or expected, to heal the wounds of my department; nor do I see this as a possible or realistic function for any

behavioral scientist). However, it is an accurate analogy in that I spent my first several years in joining maneuvers[3]--trying to understand, to enter into, to familiarize myself with the attitudes, priorities, values of the medical community in a penetrating but nonjudgmental fashion. I think this is a valuable, indeed critical exercise for any nonphysician. I even went so far as to wear a white coat with the requisite name tag; and I was not unduly chagrined when, through some bureaucratic error, I was designated as an M.D. instead of a Ph.D.

But any good family therapist knows that the risk of joining is unconditional immersion in a system which inevitably has pathologies as well as strengths. The last several years of my time in family medicine have been spent developing a balance between fusion with and distance from my adoptive specialty. And, while my love for and understanding of family medicine have deepened, at the same time I have increasingly come to value my existential role as an outsider; to realize that the isolation of which I complained in 1980 is also the strength of the behavioral scientist, that which gives us the right to be something of a gadfly, a provocateur. Being both intimately involved with yet in some sense standing apart from the field of family medicine gives me, I hope, the ability to ask hard questions about the purpose and direction of family medicine, to take the risk of enlarging the professional and personal self-understanding of colleagues and students. It is from this position

of committed gadfly that I explore the following issues regarding behavioral scientists in family medicine today.

Perhaps the greatest danger I see currently for behavioral science faculty is that of being seduced by the biomedical, high tech mode of being pre-eminent not only in the medical system, but in society at large, of which the values and priorities of the medical system are in large part simply a faithful reflection. This concern has its roots in the history of family medicine as well as its current state, and I would like to briefly elaborate on both of these for a moment.

It is not too exaggerated to state that the specialty of family medicine came into existence in large part due to what has been referred to as a "paradigm shift".[4] Family medicine emerged on the medical scene as a result of a shortage of primary care physicians, a disillusionment with the vast numbers of specialists and subspecialists being produced by the medical education system. Behavioral scientists were initially wedded to family medicine programs in the fond hope that they could be guarantors and extenders of the specialty's unique characteristics[5,6]--notably, its focus on the patient as a whole person existing transformationally in the context of family, community, and culture.

But in the eighties, another paradigm shift has occurred, which makes the above rhetoric sound a bit quaint and old-fashioned. These days, there is not much talk of the whole person. Instead,

the focus is on developing subspecialties within family medicine,[7] developing data bases,[8] developing fiscal opportunities inherent in assuming the gatekeeper role for the evolving health care system. If the doctor-patient relationship is mentioned, it is often in the context of using interpersonal skills to avoid malpractice suits.[9] As family medicine comes of age in the medical community, there are increasing pressures to join the medical establishment by wholeheartedly endorsing the establishment's values, priorities, and approaches. It appears that by doing so, family medicine can at last be recognized as "one of the boys."

Thus, in the clinical arena, the emphasis for the behavioral scientist is increasingly on providing quick fixes for, if not the patient's problems, at least for the physician's anxiety engendered by the patient's problems;[10] boiling down complex theory into a few palatable magic tricks;[11] devising cookbook-like responses to common patient problems found in the physician's office; and simply welding on to the resident an additional set of skills and techniques culled from the armamentarium of psychology. It appears there is little time or energy to do much else.

In the area of research, the behavioral scientist, particularly at the Ph.D. level, also is affected by this quest for legitimacy in the eighties. Academicians outside the specialty point with alacrity to the lack of established research traditions and a paucity of active researchers in family medicine.[12] The behavioral

scientist, trained in research methodology, is at risk for fulfilling in an unquestioning fashion the research fantasy of many departments; in a sense, becoming a department's research justification. The behavioral scientist may end up being hired for his or her vita, for the grants he or she can bring into the department, with insufficient attention paid to the potential contributions this individual can make to the overall development of the field. This person can easily become isolated from the basic training functions and vision which should inform any department. On a broader level, there is unfortunately insufficient theoretical attention paid to the nature of research itself and types of research methodologies employed which will be most relevant to the field of family medicine.

The essential point here is this: it is not only what the medical community wants, it is what the medical community needs from the behavioral scientists, and these two are by no means always identical.[13] Physicians, pressured by and reflecting the desires of the larger society, may want skills, techniques for dealing with their patients in efficient, nonambiguous, and solvable fashions. They may want ongoing activities which justify them in the larger medical system and the larger society--funded grants, research laboratories, prestigious publications in Science and JAMA. What they may need are approaches to and ways of being with and understanding themselves in relation to their patients which are

challenging, ambiguous, and risky; and cognitive and emotional tools for considering and reconceptualizing the future of family medicine (including the research future) in radical and innovative ways, which draw on the strengths of the reductionistic, biomedical models for the advancement of knowledge but are not restricted to these methodologies.

## WHAT SHOULD BEHAVIORAL SCIENTISTS BE DOING?

The role of the behavioral scientist in family medicine must of necessity and by definition be multifaceted. Again, I must reiterate that the dimensions I am about to emphasize by no means comprise an exclusive universe. However, I believe they should be on the short list of any serious behavioral scientist.

First, the behavioral scientist in family medicine has the unique opportunity to function as a visionary, a co-creator of goals and aspirations toward the future. In family medicine, a unique situation exists in which a single discipline is driven, at least theoretically, by the input of several specialties (in addition to family medicine itself and other primary care specialties; e.g., psychology, sociology, anthropology, medical social work to name a few). The behavioral scientist has an essential role to play in the ongoing process of defining the field of family medicine, formulating its assumptions, and asserting its direction. If we abrogate this role, we degenerate quickly into hired hands, brought in simply to perform specific functions and tasks. However, as co-

creators, co-inspirers, we have the rare challenge of using in a creative and unique fashion that which sets us apart from the physicians with whom we work, i.e., our differing world views and perspectives on the nature of health and illness. For there to be true integration and amalgamation at the daily level of role performance, we must have integration at the theoretical, visionary level.

Perhaps an even more critical role for the behavioral scientist is that of teacher--but what do we teach? A glance at Figure 1 may be helpful in this regard. Figure 1 is a partial representation of the multitudinous instructional avenues available to the behavioral scientist. We may teach about the person of the physician and/or the person of the patient, each informed by their idiosyncratic personal histories and families of origin. We may teach about the plethora of diagnostic, decision-making, technical, and interpersonal skills which are prerequisite to the conducting of a competent interview. But at the core of what we should be teaching is the interaction of patient and physician. This is the centrality of physicians' professional being; it is the meat and potatoes of their daily experience; and it is the access point through which all other knowledge, whether theory or research, must ultimately pass.

A recent report in Family Medicine[14] highlighted the association of strong behavioral science teaching with increased patient satisfaction in the area of the art of medicine. I am glad

to see this association documented, because I believe this is an essential part of what behavioral science educators should be doing--identifying, defining, conceptualizing, clarifying what the art of medicine is all about. In this age of highly technological and specialized medical care, personal interaction with patients is becoming increasingly important. In fact, the efficacy of medical interventions often depends on a complex context of psychosocial and attitudinal factors, many of which seem irrelevant in the research laboratory, but which take on new significance in the arena of patient care. In the real world of human patients, the success or failure of new technologies and groundbreaking medical procedures is clearly related to the attitudes, emotions, behaviors and cognitions of the patients and families who must accept and integrate these "medical miracles" in order to lengthen and improve the quality of their lives. Such success or failure is also related to the sensitivity and psychosocial skill of the resident in identifying and working with these responses in his or her patients and in himself or herself.

From Flexner on,[15] there has been an assumed context for medical training, the context in which medical advances and biotechnical progress were to occur. Flexner spoke of medicine as a calling, and it is clear that he expected physicians to be committed, caring, and compassionate healers. For the subsequent almost eighty years, medical education (including residency

training) has served this ideal with rhetoric alone by and large. While vast sums of research money and time have been invested in refining the biological basis for medical training, very little has been dedicated to an informed and systematic understanding of how to develop an educational focus which would promote attitudes of caring, compassion, and understanding in physicians. It is also assumed that while these are important attributes, they can be acquired "along the way," through the daily practice of medicine. Unfortunately, often the exact opposite attributes are absorbed.

"The physician owes the patient a sensitive understanding, a responsiveness that goes beyond presenting symptoms to include the phenomenological plight of the patient," writes SB Sarason,[16] a clinical psychologist who has worked in medical settings for 30 years. As Sarason points out, the question we normally ask as educators is, "What do we want a clinician to know and to be able to do in a technical sense?" What we need to ask may be more along these lines: "What kind of person do we want the clinician to be, and how do we help such a person become that?" We typically ignore the human, personal context of the resident, to the detriment of physician, patient, and ourselves.

In the enthusiastic rush toward more and more sophisticated diagnostic and procedural refinements, we tend to forget that illness is both an objective and a subjective experience.[17] If there are significant differences between how the patient interprets

and views a given illness, how the family interprets the illness, and how the resident interprets this same illness effective treatment can be seriously impeded. Often there is a serious discrepancy between the "voice of medicine" and the "voice of the real word."[18] For example, the patient is often concerned about how daily life will be affected by the disease just diagnosed, while the resident focuses on medical and pharmacological implications. The resident who rarely speaks in the voice of the real world is, in effect, closing the door on a more complex but infinitely more complete relationship with the patient. Figure 2 provides some heuristic guidelines for residents to help them assess the quality and texture of their patient relationships.

Napodano writes movingly in Values in Medical Practice that "patients expect the physician to become involved in the illness; that is, to take on some of the sufferings and concerns of the patient."[19] In a similar vein, in The Silent World of Doctor and Patient, Katz refers to the "intimate, anxiety-producing, and fateful encounters between physician and patient," and warns that, "what the physician fears in himself, he cannot allow the patient to express."[20] How can we teach a resident to "take on" some of the patient's sufferings and concerns? How can we help a resident to understand some of the personal fears and shadows which inform his own behavior? Currently, we have few satisfying responses to these questions.

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Recently, there has been much interest in the professional literature in applying concepts of preventive medicine to those in the healing professions.[21] Enthusiasm for preventing burn-out and stress among health care professionals is flourishing. I would argue that, while prevention of burn-out is a noble goal, it is impossible to navigate life without receiving some wounds. The real key may be not in attempting to completely prevent woundedness in our residents, which to me seems one of the conditions of life, but in helping them to recognize, acknowledge, and understand their own woundedness, as a way of bringing them closer to the distress and sufferings of their patients. To truly be healers of patients and families in distress, our residents must first start a process of emotional healing within themselves. When fear, defensiveness, or anger are brought to interactions with patients and families, the emotional result is a sense of distance and negative judgment. Patients and families, when confronted by the reality of illness, may begin to perceive themselves as broken and imperfect. To the extent that the resident accepts that perception out of his or her own personal struggles, he or she contributes to their distress. Once the resident can begin to view patient and family from a context of personal wholeness, a significant healing transformation will have begun.[22]

We delude ourselves when we assume it is easy to teach residents how to care about and connect with their patients as other

human beings. Most residents wish to be caring and compassionate physicians; but there is a great range in the willingness to actually undertake the necessary process of understanding, committing, extending. These all involve pain, inconvenience, self-sacrifice, personal change. Further, even when resident resistance is not an issue, we have few reliable tools and methodologics at our disposal. Also, in this area, we may be as ambivalent as the residents we claim to teach. There are indeed formidable obstacles to the systematic, intentional development of "art of medicine" skills among family medicine residents.

In the March 1987 issue of Newsweek,[23] a young resident wrote movingly of the death of his father. Toward the conclusion of the article he stated, "My father was no more difficult than many other patients but something was sorely missing from his care. And it wasn't highly technical procedures. Attitudes toward patients are picked up early. . .And the gaps in empathy and simple humanity do not magically disappear."

Cries of disappointment and anguish such as this appear with depressing regularity; this one was selected simply because of its recentness, not its uniqueness. The cries themselves provoke dismay and alarm, possibly even motivate a few curricular changes, or the formation of ad hoc committees. But their very regularity suggests that the gaps to which Dr. Rosen referred are not taken seriously enough. To be honest, I am not sure that we, as educators, know how

to fill them. We may not even be willing to learn.

When I initially joined a Family Medicine Department, I was struck by the rudimentary knowledge possessed by most residents about psychological theory, research, and practice. At that time, I felt that teaching of such knowledge would have to be approached in a fairly basic way. What I barely grasped at the time, but which since then has taken on an enormous importance for me, is that most residents possess only a very rudimentary knowledge about and acquaintanceship with themselves, their moral, emotional, spiritual, sometimes even physical beings. Without this, theory, technique, and research findings are all virtually useless in clinical application. This self-understanding, in relation to themselves and to others (in the context of a residency program, particularly in relation to patients, peers, faculty, and staff; and to a lesser extent, to spouses, children, parents, friends), must be where we start.

It seems to me we have a very basic task. As behavioral scientists, we do not have the time and resources to teach family physicians to be counselors, family therapists, researchers. But we can help them become more aware and compassionate human beings. Thus, I think the greatest priority in behavioral science is not teaching our residents to help their patients, but teaching them to help themselves. We are there less to teach "the subtleties of psychological principles," as I phrased it in my original article,

and more to teach them some of the subtleties about themselves, and about themselves in relation to their patients. We are there to help them recognize some of the unstated fears and implicit meanings which transpire almost every time a physician and a patient come together.

Now, more than ever, it is important to return in clinical practice to the Socratic injunction, know thyself. Although Balint's two-person psychology[24] is only fleetingly referred to nowadays, the timelessness of this goal is acknowledged by the continued existence of "Balint" groups, which stress the value of intuitive insight in clarifying the relationship between doctor, patient, and illness. Interestingly, Balint's primary goal was quite modest, i.e., to make "the interference by the physician's own psychopathology in his (sic) work minimal."[25] This statement implies that physicians are not immune from dysfunctional attitudes, feelings, and cognitions which, if left unchecked, can significantly interfere with effective patient care. By contrast, it is implied that awareness of less than optimal reactions to patients and their families is a critical first step in learning responses that enhance the well-being of both physician and patient.

I have frequently been told that there is no time to take this approach with residents; you cannot do therapy with residents; you will never complete the assigned curriculum if you start at such a basic level. Often, the protestations seem compelling. In fact,

however, as teachers, we can ill afford not to attend to these dimensions, because they are at the core of the physician-patient relationship. Rationalizations such as "not enough time" or "irrelevant and inefficient" may sometimes be excuses for the resident's discomfort in loosening control of a person-to-person encounter,[26] of risking moving the encounter from an I-It to an I-Thou level.[27] On the other hand, if, as behavioral science faculty, we can participate in the personal healings so needed in the lives of many residents, I am confident that the acquisition of behavioral science skills, techniques, and academic knowledge will follow.

Thus, in looking retrospectively, I am less concerned with transmitting the high-tech aspects of psychology and behavioral medicine: nonpharmacological approaches to chronic pain; biofeedback treatment of headaches; the use of hypnosis in clinical practice--not because these are not worthwhile techniques, but because they appear seductive to the physician--they put him or her back in a familiar region--applying a technique to a patient. I am no longer so concerned with teaching interviewing skills per se, or insisting that residents have absolute versatility with DMS-III. I am no longer inclined to discuss with residents the 12-minute psychotherapy hour, or the 7-minute psychotherapy hour.[28] Connecting with patients, establishing a personal, I-Thou relationship requires some time, some commitment. For some things, there are no shortcuts. Similarly, I am more aware of the

limitations of behavioral checklists and objectives for training residents to competency.[29] It is not that there is no place in resident education for such tools; indeed, they are often helpful to anchor vague anxieties about residents, to help us pay more sincere and particular attention to those whom we are supposed to be teaching. It is merely that such devices, which are only a means to an end, may become confused with the end itself. We cannot teach about love, anger, compassion, humility, through behavioral checklists alone. We need, on occasion, to risk the reality of interpersonal encounter with our residents, to listen to them without the buffer of a behavioral objective to be achieved.

In this regard, as Howard Stein eloquently points out, there is an important distinction to be made between interviewing a patient and dialoguing with a patient;[30] and I believe we must teach both modes. Some might argue that there is no room for dialogue in the doctor-patient encounter. On the contrary, that this a crucial, indispensable aspect of the healing relationship. We must above all resist the tendency in our residents and ourselves to reduce interpersonal encounters to depersonalized, mechanistic, technique-oriented experiences. An interviewing skill without a context of compassion and understanding remains just that, a skill, and like any other skill, it can be inappropriately applied. Therefore, we must focus less on teaching the technique, and more on teaching the context of the technique. Although it is infinitely easier, we must

avoid teaching only the technology of psychology (or anthropology or sociology). Simply stuffing residents full of facts and skills will not fill the void experienced so often by ourselves as teachers, by patients, and by the residents themselves.

Two telling examples of the potential distortions of a technique-oriented approach come to mind. I recently observed a resident interviewing a patient, who was describing his recent return from a fishing trip. The resident interjected, "I think fishing's great, too!" Later, I congratulated the resident on a self-disclosure likely to create a future bond of intimacy between himself and his patient. I happened to ask what type of fishing the resident preferred. The resident informed me he had not been fishing since he was a boy, but that he was trying to practice a technique he had recently heard discussed at a behavioral science seminar. It is probably superfluous to add that the irony of this situation was lost on this particular resident.

In a similar example, I participated this year in a painful encounter in which a 3rd year resident had to inform a 50-year old woman, accompanied by her 25-year old daughter, that the mother was suffering from melanoma. After the resident communicated this diagnosis in a clear and simple fashion, I suggested that he ask about what the mother and daughter were feeling. At the time, I had a strong sense that the resident was significantly more comfortable making the necessary arrangements for further work-up than he was

re-entering the treatment room. At last, however, the following dialogue occurred:

Resident: So, how are you feeling about all this?

Mother: (Silent, tears in her eyes.)

Daughter: Well, we are Christians. We believe it is in God's hands.

Resident: (Relieved) Oh, good. (End of interaction.)

Technically, it could be argued that the feelings of patient and family member in this situation had been "addressed." However, what was unhappily evident was that, while the resident in question was willing to give passing acknowledgment to a "required" query, he was unable or unwilling to risk being truly present in the face of this family' palpable distress. A behavioral checklist might reflect that a probe regarding feelings had indeed been asked, but might fail to note that the resident had avoided entering into the family's phenomenological experience.

Pursuing this line of thinking one daring step further, I have even become less enamored of the flash and sizzle of family therapy. I am less impressed by residents who move family members around from seat to seat, who experiment with family sculpture on home visits, who require patients to complete genograms to while away the two-hour wait in the reception area, and which are never looked at again. All of these are potentially rich and useful techniques--but they are just that, techniques. When they are uninformed by a

larger context of understanding and compassion, they are open to abuse and misuse. Physicians (and Americans in general) have a fatal weakness--we love gadgets and technology. We would do well, in the teaching of family medicine, to avoid falling prey to this passion for solving people's pains and problems through the introduction of ingenious "tricks" even when they are ordered from the fashionable supply house of family therapy.

Michael Crouch wrote a beautiful article about a year ago in Family Medicine chronicling his struggle toward intimacy, independence, and resolution with his own family of origin.[31] In examining themes of death, individual specialness and openly expressed affection, he courageously speaks of how his own family issues detracted from his practice as a physician. This is not a unique, but rather a universal phenomenon, and one that is insufficiently addressed in resident training. Dr. Crouch then suggests certain useful questions for the physician to raise when the doctor-patient relationship is unsatisfactory: How might my own family patterns be playing a part? How can I change my part of the interaction to avoid repeating dysfunctional family patterns? But these and other similar questions are predicated on a certain level of self and family-of-origin awareness, or at least the desire and motivation to develop this awareness and understanding.

A resident who has examined and resolved some of his own family hurts will be highly motivated to learn more about family therapy;

conversely, a resident who is spoonfed structural family therapy techniques will find them only confusing, frightening, or irrelevant. We must stop being obsessed with filling our residents so exclusively with information. This approach alone will not address the emptiness and confusion that exist in so many of these young men and women who are our responsibility to teach, and yes, to nurture. We must also risk examining how this flood of theories and data touches their lives personally, how they as people interact with the knowledge we expect them to apply so glibly to the lives of others.

If all this sounds uncomfortably like therapy, I think that is because in certain respects it is uncomfortably like therapy. I am certainly describing a process of education which is intimate, personal, transparent, open, and risky, all adjectives which describe psychotherapy as well. However, I am really only talking about encouraging residents to take the risk of truly encountering their patients; to dare to listen to them; and to know themselves well enough to differentiate between their own needs and their patients' needs.

Not unlike physicians, we too, as behavioral scientists, have a need to justify ourselves. An elaborate, well-formulated curriculum may provide an excellent safety net against our own sense of peripherality. However, it may be more useful to spend a behavioral science teaching session simply talking with residents about who

they are, what is happening in their lives, than to lecture on the latest pharmacological interventions for depression. The latter information can easily be accessed from the nearest biomedical library. The former knowledge may never be accessed.

In terms of priorities, I think it is essential to first deal with residents separated from their wholeness, their completeness, their integrity, their emotions, their humanity. Thus, primary goals of behavioral science teaching should include the deepening of self-awareness in residents; a commitment to personal growth and maturation; a greater ability to function effectively and creatively in situations of ambiguity, anxiety, and risk; an increased acceptance of one's own limitations and imperfections; and a pursuit of mutuality, authenticity, and openness in communication with patients, peers, and faculty.

**HOW TO DO WHAT IS PREACHED**

The real question, which I have carefully avoided thus far, is how to do all this; how to teach self-awareness, caring, and compassion for others? I am not convinced we have all the answers, particularly in light of the paucity of convincing research in this area. However, from personal experience, I would like to make a few points.

I do not propose startlingly radical solutions, although they may be somewhat radical in their consequences. I am not in favor of dumping organized curriculum, nor am I scornful of teaching

objectives. Opportunities for real teaching and true healing abound in the day-to-day course of faculty-resident exchanges. The structured curriculum itself can become a vehicle for creating I-Thou encounters between teacher and resident, resident and patient. The whole premise of this approach to teaching is a spontaneity and authenticity, a willingness to embrace, rather than avoid, the resident's confusion, the patient's pain.

First, we need a systematic examination of the artistry of medicine, the competence by which skillful clinicians actually handle indeterminate zones of practice.[32] To do so, we must carefully study the performance of unusually competent practitioners. This artistry must further be analyzed into its component parts; e.g., the art involved in problem-formulation, the art involved in implementation of solution, and the art of improvisation--until each is better understood and more easily replicated.

In residency training, we have an ideal model for teaching the artistry of medicine: a model which emphasizes practicum, tutorial, apprenticeship, coaching, and modeling. But all too often we ignore the possibilities of this model, and treat is as a mini-professional school. In an area which should highlight art, we stress exclusively technical rationality. We need to think about ourselves less as teachers, more as coaches, in the sense of an athletic coach or a music coach, who respect technique, but who also

help learners rediscover their own creativity, experimentation, and risk-taking.

Several examples of such educational choice-points occur to me. In one instance, a resident discussing his experience on a pediatric rotation, commented in an aside, "When I look at these kids, I don't feel a thing." This remark, which could easily have been ignored, instead provided an opportunity for exploring the frightening deadness of affect which was besetting this individual.

In another situation, a patient remarked, after learning she had COPD, "Well, I'd better either stop smoking or shoot myself right away." The resident responded to this comment by saying, "You know, the decongestant you were asking about probably won't be very helpful." After some discussion, the resident returned to query her patient further, and began to understand some of the desperation and denial which had contributed to this patient's irregular appearance in clinic and medical noncompliance.

In a final example, a resident considered the "golden boy" of our program because of his cheerful demeanor, helpfulness toward other residents, and involvement with his patients, passed me in the hall one day and remarked: "I had the strangest dream last night. I was the captain of the Titanic, and the passengers on the ship had the faces of my patients, and my friends, and my family, all the people I cared about. I knew I should save them all. But I was very tired, and all I could think about was jumping overboard, you

know, just leaving them all behind. But I woke up as soon as I hit the water, and I hadn't gotten away from anything." I asked him whether he thought this dream meant anything. He laughed and replied: "Well, of course it's obvious, but no, it doesn't mean anything (in the sense that it doesn't matter). It just means internship is hell."

All these examples have a common theme: they do not have textbook responses or solutions. No textbooks discuss how to deal with residents who feel they have turned to stone. No textbooks tell us what to do about residents' dreams. And while the books do tell us how to deal with suicidal patients, they are less explicit about patients with chronic lung disease who drop joking remarks about shooting themselves. Thus, because the gaps between research and theory and practice remain large, we often find that the certain, the tangible, the demonstrable, is taught, while the intangible, the ambiguous, the uncertain is ignored, although it may hold equal if not greater importance for both patient and physician.

In trying to teach understanding, awareness, and compassion, in part we must teach by example. We must do toward our residents what we ask them to do toward their patients: observe them with respect and caring, listen for the themes which organize their lives, listen to their stories, attend to their hurts, be willing to focus on their personhood. In this regard, we have a unique and challenging opportunity to use the persons of ourselves to model what we ask our

residents to do in the doctor-patient relationship. In addition, there exists an abundance of teaching exercises to help residents explore these issues. For example, I have an regularly instructed residents to keep a daily log of their emotions or of their reactions to patients and various medical environments. It can also be a valuable tool to have residents keep a dream journal, as a way of discovering their non-conscious thoughts and responses. Writing a family history is a revealing way to examine family of origin issues, as is completion of a genogram. Bibliotherapy, thought-provoking articles and books (even fiction!) may also address some of the searching and identity issues which plague many residents.

Obviously, such a list could be expanded infinitely. My hope is that it will be, and by many others in addition to myself. These ideas are not particularly innovative or new. What is somewhat different, however, is the contention that they must be moved from the periphery to the core of medical culture. A common analogy making the rounds these days is that behavioral scientists are like music teachers: we provide the "aesthetic dimension," the beauty, the culture, the spit and polish; while the medical faculty teach the basics of reading and mathematics.

Such thinking, to me, is extremely dangerous and misplaced. The centrality of behavioral science contributions should, by this time, be unquestioned. Unfortunately, despite the long association of physicians and behavioral scientists, it is a vision which still

has not fully materialized as reality. It is to be hoped, however, that the creativity and risk-taking which gave birth to the specialty of family medicine can be channeled into fulfillment of the specialty's truly innovative potential. In conjunction with our physician-colleagues, it is we, as behavioral scientists, who have the responsibility for ensuring that the core of the medical encounter, the doctor-patient relationship, is taught in such a way as to become an experience of real healing and wholeness for both patient and physician.

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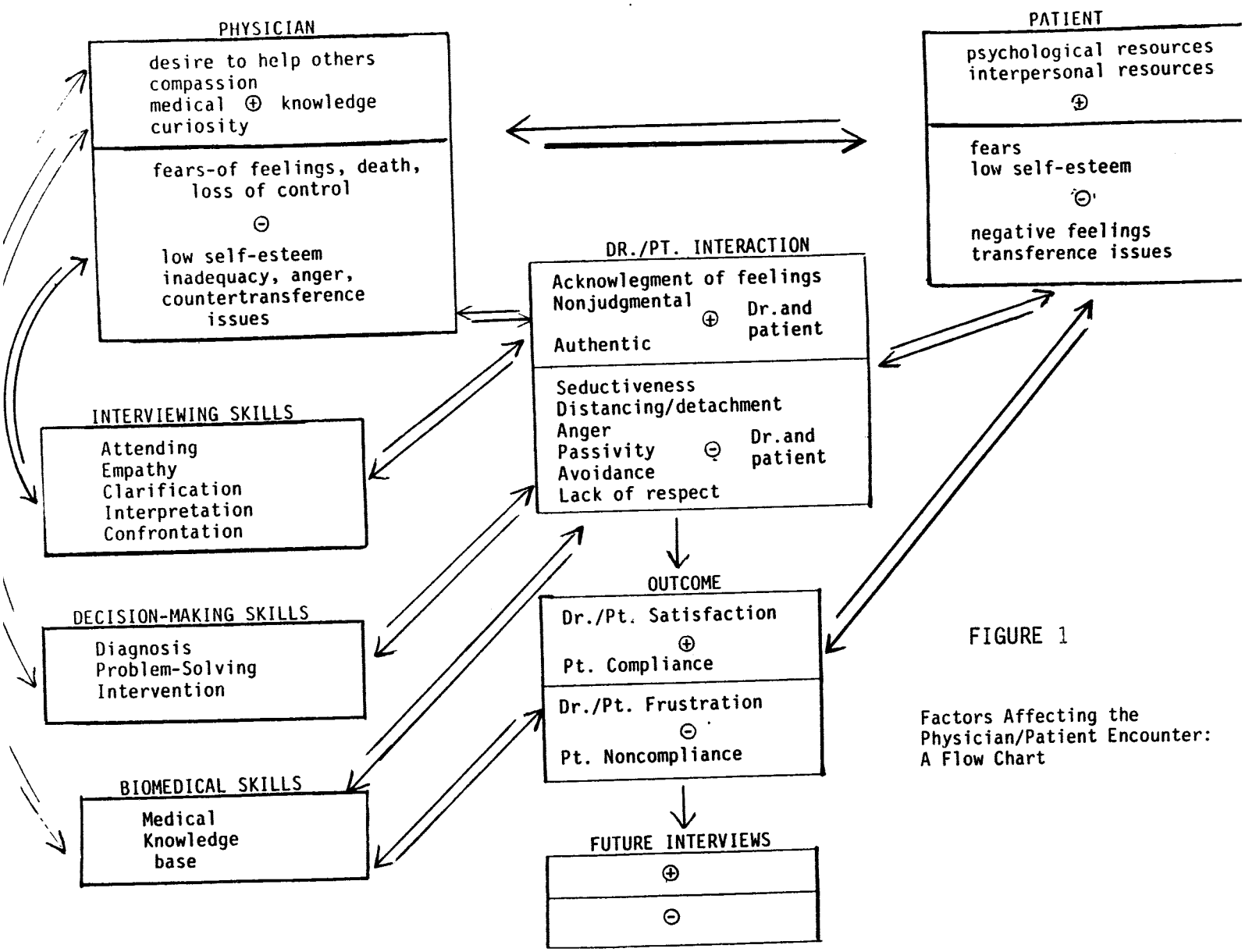


FIGURE 1

Factors Affecting the Physician/Patient Encounter: A Flow Chart

**FIGURE 2**

HOW WELL DO YOU RELATE TO YOUR PATIENTS: SOME KEY QUESTIONS

A. Patient rarely or never discusses aspects of his/her personal life with you... 1 2 3 4 5 6 7... Patient appears able to share relevant personal information openly and honestly with you.

B. Patient only talks about physical symptoms...1 2 3 4 5 6 7...Patient appears able to talk about feelings as well as symptoms.

C. Patient often appears ill-at-ease, with little eye contact...1 2 3 4 5 6 7...Patient usually seems comfortable with you and maintains good eye contact.

D. Patient is consistently noncompliant with medication and other therapeutic instructions...1 2 3 4 5 6 7...Patient is usually cooperative with therapeutic regimen.

E. Patient generally appears dissatisfied with medical care...1 2 3 4 5 6 7... Patient generally appears satisfied with medical care.

F. You feel uncomfortable when you see this patient's name on your schedule...1 2 3 4 5 6 7...You are comfortable at the thought of a return visit with this patient.

G. You know very little about this patient's personal and family situation...1 2 3 4 5 6 7...You have an adequate data base about this patient's family, including information about family strengths and weaknesses, risk factors, and chronic or acute stressors.

H. You have feelings of irritation and annoyance when you think of this patient... 1 2 3 4 5 6 7...You feel genuine interest and concern for this patient's wellbeing.

I. There is frequent miscommunication with this patient...1 2 3 4 5 6 7... Communication with this patient is generally open, clear, and honest.

J. You feel you are usually pretending with this patient...1 2 3 4 5 6 7... You feel you can be genuine and authentic with this patient.

K. You feel this patient is very dissimilar from yourself and hard to understand... 1 2 3 4 5 6 7...There are many levels on which you understand and empathize with this patient.

L. Your view and the patient's view of the patient's illness are very different... 1 2 3 4 5 6 7...You and this patient have a mutually agreed upon understanding of this patient's illness.

NOTE: Higher scores usually indicate a better functioning relationship. However, checklist is not a formal assessment device, and should be used simply to indicate to the physician some possible areas of strength and weakness regarding relationships with patients.