# The Maturing of Family Medicine: Challenges to Behavioral Science

Johanna Shapiro, PhD
*Orange, California*

In recent years much has been written about the evolving nature of family medicine as it seeks to come of age in a time of great societal demands and shrinking fiscal resources.[1] The paradigm shift[2] in the world of medicine (away from exclusive focus on subspecialty medicine and toward a biopsychosocial understanding of the patient as a whole person) that created the specialty has given way to other paradigm shifts. One current trend emphasizes academic rigor, scholarly productivity, and the development of scientifically sound research directions. Reflecting a completely different emphasis, another paradigm shift has occurred toward "gatekeeper economics." These developments pose formidable challenges to family physicians, and the changing face of family medicine has profound implications for behavioral scientists as well.

At issue is what role behavioral scientists will play in helping to shape the future of family medicine. Interdisciplinary integration has been a much-sought-after but elusive goal for both behavioral scientists and family physicians over the last 15 years.[3] Too often, despite the best intentions of all concerned, the behavioral scientist has been relegated to the role of helpful handmaiden. If this role persists unchallenged into the maturational phase of family medicine, there is little hope of ever achieving the integration of physician and nonphysician that was inherent in the earliest visions of the specialty.[4] In considering both the dangers and possibilities that await behavioral science in the future, two arenas reflecting the abovementioned paradigm shifts must be addressed forcefully.

***Nature of Research: Is Scholarly Rigor Only of One Type?*** Family medicine's recent quest for academic legitimacy,[5] while a much-needed, essential step in the lifecycle development of the specialty, is also subject to potential distortions from the viewpoint of behavioral science faculty. The behavioral scientist, usually with a strong background in research design and methodology, suddenly may become at risk for fulfilling in unquestioning or mechanical fashion the research fantasy of a department (in a sense becoming a department's research justification). New behavioral science faculty may be recruited only for their impressive research vitae, for the grants they can bring to the department, with insufficient attention paid to their long-term commitment and overall understanding of the field of family medicine. Such a role for behavioral scientists can easily isolate them from the broader training functions and vision that form the core of any department. Thus there is a potential tendency to see behavioral scientists as a means to an end, in this case the production of data and publications, instead of part of an interwoven, collaborative context.

For their part, behavioral scientists must also be prepared to rethink their traditional research methods and previous research interests. In the early years of family medicine, it quickly became apparent that behavioral science clinical skills could not be arbitrarily transplanted into family medicine soil or grafted in their original form onto family medicine residents. Similarly, behavioral scientists must not ignore the chance to explore and experiment with innovative research approaches and questions that capture the essence of their adoptive specialty, simply out of a desire to satisfy the research expectations of the medical community at large. It is possible that the quantitative-agrarian methodology may have its limitations when applied to family medicine.[6] The research questions considered fascinating by health psychology professionals may be only tangential to family medicine's most pressing concerns. Thus, pressures to churn out research in bulk must be avoided; instead, behavioral scientists should work closely with family physicians to develop a strong theoretical context and methodological foundation that can inform family medicine as a truly unique forum for scientific inquiry.[7]

***Clinical Teaching: Techniques in the Context of Self-understanding and Caring.*** In terms of clinical teaching, family medicine originated as a specialty characterized by a committed focus on the patient as a whole person existing

*Submitted, revised, January 20, 1988.*

*From the Department of Family Medicine, University of California, Irvine, Orange, California. Requests for reprints should be addressed to Johanna Shapiro, Department of Family Medicine, University of California, Irvine, 101 The City Drive South, Orange, CA 92668.*

transformationally in the context of family, community, and culture.[8,9] Now, however, there are multiple pressures emerging from the gatekeeper role in the health care system to practice high-volume, compartmentalized medicine. A potential consequence of the bottom-line approach to the practice of medicine is the pressure for the behavioral scientist to provide quick fixes for, if not the patient's problems, at least the physician anxiety engendered by the patient's problems,[10] to be able to boil down complex theory into a few palatable tricks or stratagems, and to be willing to serve up cookbook-like responses to common patient problems. If the physician-patient relationship receives attention, it is increasingly in the context of learning to utilize interpersonal skills to avoid malpractice suits.[11]

In the enthusiastic rush toward claiming its rightful place among other medical specialties, there is the danger that family medicine will leave behind its concern for the phenomenological experience of the patient[12] and the essential vulnerability of the physician.[13] It is critical that the behavioral scientist, as clinical teacher, not be suborned by this trend. Rather, the teaching function of the behavioral scientist must continue to be helping residents learn how to assume empathetically some of the patient's sufferings and concerns,[14] to distinguish between the voice of medicine and the voice of the real world,[15] and to probe their own life histories, which inevitably color interactions with patients.[16]

Although it is infinitely easier, because it dovetails so conveniently with contemporary high-technology, subspecialized approaches to medical education, an exclusive focus on transmitting simply the technology of behavioral science must be avoided. In providing physicians with skills, it is also the behavioral scientists' responsibility to help physicians understand the context in which those skills must be exercised, the unstated anxieties, implicit meanings, and subjective interpretations that exist whenever a physician and patient come together in an I–Thou encounter.[17] Potentially rich and useful techniques such as the genogram or the Family APGAR remain only techniques when isolated from a larger context of understanding and compassion.[18]

## SUMMARY

For family medicine to maintain the unique creativity and risk taking that were present at its inception, behavioral scientists must be allowed to play, and be willing to assume, an essential role in the ongoing process of defining the field of family medicine, formulating its assumptions and asserting its future direction both in terms of academic research and clinical teaching. As co-creators and co-inspirers, behavioral scientists have the rare challenge of synthesizing their perspectives and values with those of the physicians with whom they work. It is to be hoped that through this interactive process, the practice of family medicine will continue to be an experience of real healing and wholeness for both patients and physicians.

### References

1. Scherger J: Priorities in family medicine: Residency training. Fam Med 1987; 19:177–179
2. Kuhn TS: The Essential Tension: Selected Studies in Scientific Tradition and Change. Chicago, University of Chicago Press, 1977
3. Shapiro J: A revisionist theory for the integration of behavioral science into family medicine departments. J Fam Pract 1980; 10: 275–282
4. Johnson AH: Behavioral science in family practice: An ethical imperative. J Fam Pract 1977; 4:525–528
5. Colwill JM: Academic departments of family medicine: A retrospective and a prospective view. Fam Med 1986; 18:384–388
6. Kuzel AJ: Naturalistic inquiry: An appropriate model for family medicine. Fam Med 1986; 18:369–374
7. Gordon MJ: Research traditions available to family medicine. J Fam Pract 1978; 7:59–68
8. McWhinney IR: An Introduction to Family Medicine. New York, Oxford University Press, 1981
9. Ransom DC: The evolution from an individual to a family approach. In Henad S, Grose NP (eds): Principles of Family Systems in Family Medicine. New York, Brunner/Mazel, 1985, pp 5–23
10. Stein HF: The influence of countertransference on decision-making and the clinical relationship. Cont Educ Fam Physician 1983; 18: 625–630
11. Beck JT: Teaching Residents How to Avoid Malpractice Suits. Presented at the 20th Annual Meeting of the Society of Teachers of Family Medicine, New Orleans, April 25–29, 1987
12. Sarason SB: Caring and Compassion in Clinical Practice. Jossey-Bass Publishers, San Francisco, 1985
13. Maslach C: The cost of caring. In Farber BA (ed): Stress and Burnout in the Human Service Professions, New York, Pergamon, 1983
14. Napodano RJ: Values in Medical Practice. New York, Human Sciences Press, 1986
15. Mischler EG: The Discourse of Medicine: Dialectics of Medical Interviews. Norwood, NJ, Ablex, 1985
16. Crouch M: Working with one's own family: Another path for professional development. Fam Med 1986; 18:93–98
17. Buber M: I and Thou, ed 2. Kaufman W (trans). New York, Scribner, 1958
18. Hilfiker D: Unconscious on a corner. JAMA 1987; 258:3155–3156