Part TALBOT 2-22-88

THEMES IN NINE INTERVIEWS WITH PHYSICIANS AND BEHAVIORAL SCIENTISTS ON TEACHING ABOUT THE FAMILY

I. SITUATION IN WHICH YOU FELT MOST LIKE FAMILY DOCTOR (N=4)
dealing with life cycle issues (death of husband/pregnant wife)
dealing with loss, grief, interpretation and reassurance of symptoms (60 yr. old woman w/chest pain - husband died prev.yr.)
when sees second member of family and can link up some knowledge of family dynamics from first member with what's going on with patient
family counseling situation - evaluation of child for attention deficit disorder where both family dynamics and medical skills needed (balanced presentation - physician allied with family, whether needs are biomedical or psychosocial)

IV. 3 OUTSTANDING RESIDENTS: SIMILARITIES AND DIFFERENCES
physician - all face learning how to cross barrier between practicing medicine and practicing family medicine
importance of faculty sensitivity to different levels of expertise
receptivity in resident - each level has its rewards
higher levels - just provide feedback, few suggestions
importance of teaching resident they're part of the system
behav. sci. - similitaries:: all have similar attitude, a shared belief system
differences: one very concrete, focusing on data-gathering (who's in the family); another displayed active involvement - intervention; third exhibited molre internal changes- thought more systemically about pts.
physician - 1) know how to assess family in terms of structure and function (discipline, rules, communication, agreement/communication, agreement/conflict) 2) can document this material in chart 3) on basis of interview data, can tell what kind of family issues are active, and be able to anticipate problems 4) do not necessarily deal with family issues in every family, but have that level of awareness to be prepared to intervene systemically as necessary 5) know distinction between primary care and referred care: primary care:
a) responds to direct education, suggestion, homework assignment
b) family fairly functional, can make and keep contract
c) family will respond to supportive counseling
physician - similarities: all need to have awareness impact on family and vice-versa
differences: residents have different goals: some very interested in family; others feel more of an obligation to pay attention to family

Less interested resident is a challenge - can either frame as chance to open up window or hold it against the resident to create a positive shift away from resentment:
1) be aware of tension and try to understand what it's about
2) step away emotionally and reframe own thinking more positively
behav. sci. - similarities: all learned core things: moved away from working with individuals to working with more than 1 person
differences: had different goals because had interests in different kinds of patients
very different as people: one started as antagonistic, but ended up feeling this was an approach he could use
teaching approach: wait for teachable moment: when resident is stuck, b.s. will make herself available and valuable (a chance to demonstrate that this stuff works)
avoid defensiveness, don't take rebuffs personally, and many residents will come around
developed greater sense of security; but also started framing role as that of visitor; understood b.s. is not role model for fam. physic.
beh. sci. - similarities: all came to program with curiosity about psychosocial issues, wished to learn about family; didn't have more content knowledge, but did have a different attitude
- differences: content varied from resident to resident, and was often determined by the specific clinical situation (insight that alcoholism involved whole family; learning to deal with divorce, and ensuing family relationships)
beh. sci. - similarity: all equally rewarding no matter whether at a basic or a sophisticated level
differences: one constricted, not psychologically minded, skittish but interested, and open to new ways of thinking; learned to trust his own feelings, realize his common emotional bonds with other people another - open, friendly, receptive to learning, exhibited "ecstatic" responses, and very savvy
third, interested in dealing with marital issues, with some focus on own marriage; very appreciate response
physician - resident initially resistant, but coached along by b.s. faculty
now proponent of family oriented teaching (gradual evolution)
initially encountered "brick walls" with pts. because refused to deal with behavioral side
behav. sci. - all share an attitude of psychological mindedness (awareness of unconscious motivation, conflict, inquisitiveness; innate understanding of human beings and social relations "I help them organize their sensitivity, show them how to make use of it

not possible to teach this sensitivity; need to have the attitude, then can teach the knowledge
all had acquired good family therapy skills, and could do effective brief family therapy

SUMMARY : SELECTED INTERVIEW THEMES

I. HOW DOES THE FAMILY PHYSICIAN USE FAMILY-ORIENTED INFORMATION IN CLINICAL PRACTICE?

A. Situations in which physician respondents felt most like family doctors
dealing with life cycle issues
dealing with loss, grief, interapretation and reassurance of physical symptoms
applying knowledge of family dynamics to pt. problem
family counseling situations which require balanced presentation of both psychosocial and medical knowledge

B. Characteristics of outstanding residents
able to cross barrier between practicing medicine and practicing family medicine
developing their understanding that they become part of the patient family system
shared belief system - quality of psychological-mindedness
can assess family in terms of structure and function
can document family-oriented material in chart
can determine what kinds of family issues are active, and can anticipate problems, and intervene when necessary
know how to discriminate between primary care and referral (primary care: a) family responds to direct education, suggestion, homework assignments b) family fairly functional, can make and keep a contract c) family will respond to supportive counseling)

II. HOW TO STRUCTURE A LEARNING EXPERIENCE FOR A REFLECTIVE PRACTITIONER?

A. Teaching approaches
<u>emphasis on coaching-type teaching:</u> direct observation, review of videotapes, case review, conjoint interaction with pts.: roleplaying; modeling
<u>eliciting tacit knowledge:</u> "remind them of what they already know"
<u>move from detail to generality</u>: ;"help them move from details to a broader level"
<u>help them structure attitudes</u>: "I help them organize their sensitivity, show them how to make use of it "
<u>permission-giving and empowerment</u>: "allow residents to realize it's okay in any medical situation to ask family-oriented questions"
<u>use of genograms</u> for family of resident, pt., and attending: "can help identify family and intergenerational patterns and issues"; "can provide vital link to diagnosis and treatment"
<u>immersion in direct clinical encounters</u>: "lots of experience looking at data and piecing it together; importance of having them react to live data, and form hypotheses"

B. Effective teaching
personal development of resident: help resident know own limitations; help resident become comfortable with ambiguity
"sensitivity to solutions" that deal with feelings, with families
"helping move residents along to their next stage of being" able to make resident feel safe in family interviewing situation
identify something resident has experienced with own family, and show how this can help or hinder in dealing w/pt. and family
interpersonal relations between attending/resident: establishing a sense of personal connectedness with resident
shift in world view: "help resident acquire whole new perspective on pt."
resident relaxed, natural, "having fun" in interview
"I help them to learn not to think themselves to death...not to work too hard...not to battle the data"
debriefing: execution of previous mutually constructed game-plan
post-hoc sharing of mutual reactions
resident acquired new content material
resident acquired "some sense" of how family material could be uncovered
improvisation: resident acquires ability to bring a plan to fruition, through compromise between what the resident knows and that the family gives him an opportunity to do

III. COLLABORATION BETWEEN PHYSICIANS AND BEHAVIORAL SCIENTISTS

A. Differences in teaching approaches between physicians and behavioral scientists
superficiality/depth: physicians "quick and dirty", have to work with much more limiting time constraints; tend to ask "quick questions," with little follow-up; emphasis on getting family in, rather than on what they will say when they're there
behav. sci. have better integration, more in-depth knowledge of psychosocial material, can use more refined and subtle techniques, able to work with more resistant, complex families
action-oriented/process oriented: physicians use "fix-it" mode, prefer giving directives, use "too-early interpretation;"
see psychosocial material as last resort; physicians used to having things happen;
physicians more authoritarian , dogmatic, want to be in charge

behav. sci. realize change is a slow process; behav. sci. focuses on process of patient
biopsychosocial approach: physician able to provide better integrated care; behav. sci. limited by their educational background
models: physicians better models because residents' primary concern is to be competent as physicians; behav. sci. can't inspire residents psychosocially
concreteness/abstractness: physicians more concrete, tend to focus on how many in family, rather than their interaction; focus on net result, outcomes; behav. sci. look at process, "fuzzy things"
for behav. sci. process dominates, content follows (behav. sci. sees the interpersonal relationship as the core process: "For them (physicians) it follows clinical data, for me it leads clinical data"

B. Collaboration between family physicians and behavioral scientists
importance of trust, rapport in interpersonal relationship
mutuality, recognition of equal contributions - emphasis on co-precepting, co-therapy
sharing a common biopsychosocial model, having same goals