

Case Oriented Group Discussions for Family Physicians

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Curriculum in family medicine and primary care includes various areas of concern for educators in the behavioral sciences. Most of this concerns the physician-patient relationship as the focus for teaching and learning. This paper outlines the work of a longitudinal, case oriented group of family physicians as it reflects the correlation between the actualities of practice and the curriculum in behavioral science for family practice residents. Also discussed is the issue of potential "typologies" as elaborated in the family physicians' reasons for case presentations. Such groups assist faculty and practitioners in their own awareness of educational and patient care issues in the physician-patient relationship as well as serve as a foundation for building a relevant behavioral science curriculum for residents and students.

With the advent of medical psychology in the 1950s, various groups of physicians have recently been called upon to apply psychological knowledge to the treatment of their patients. However, this notion is not new to the field of family practice. Balint^{1,2} first introduced this idea by making the distinction between "illness-centered medicine" and "patient-centered medicine." He noted that, whereas the former is exemplified by the hospital medicine of the specialist, who arrives at traditional diagnoses by asking specific questions and heavily relying on laboratory technology for answers, the latter is epitomized by family physicians, who arrive at overall diagnoses by hearing out the patient's complaints and discerning their meaning in the context of the patient's life history.

It was in this context that Balint put forth one of his major propositions for the field of family practice: that patients consult their physician when they have converted the struggle with their personal problems into an illness, about which they can more easily complain. Thus, the physician's first task is to help the patients relocate their problem so that they can complain about this true source of anxiety rather than about the illness; by so doing, the physician is, in actuality, initiating for patients the first step in the process of solving their problems.

That family physicians have been concerned with treating the "whole person," often including psychological problems, is well documented. For example, contemporary textbooks in the field of family practice characteristically include chapters on the treatment of psychological illnesses.³⁻⁵ It is not surprising that, when authors such as Stephens⁶ and Groves⁷ describe prototypic "troublesome patients," these patients are the ones with hidden agendas. This can be illustrated by the patient who comes in with chronic complaints of diffuse pain; during the interview, however, these

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pains are found to substitute for some underlying psychological problem, such as marital difficulties or general life stress.

The goal of this paper, then, is to explain how one group of family physicians deals with the psychological aspects of physical illness, as exemplified in the patients they treat. More specifically, it deals with the establishment of meetings by faculty family physicians in the family practice residency program of the University of Massachusetts Medical School, as a means of learning to deal with this "new realm" of problematic patient situations.

Thursday Morning Group meetings, which have been in existence for over four years, are held weekly for an hour and a half. The group consists of nine practicing faculty family physicians and one psychologist, who is the coordinator of the sessions, the "leader" role being de-emphasized. In attendance also is a doctoral student in clinical psychology, who tape-records the sessions and prepares summaries of the meetings, which are subsequently distributed to all group members.

It should be noted, however, that although the range of group activities is large, the majority of the sessions is spent on the presentation of difficult patients. For example, over the past year, 70 percent of all sessions were devoted to such discussions as opposed to other group activities.

Given this emphasis on the presentation of difficult cases, the current paper poses two major questions: (1) Is there a correlation between the actualities of practice and the behavioral science curriculum designed by teachers of residency programs? That is, in the course of a year, will group members spontaneously bring up patients who cover the range of issues and topics that are ordinarily covered in the standard behavioral science curricula for family physicians? and (2) To what extent are the generalizations about patient "typologies," such as those proposed by Groves, adequate for dealing with the actual cases covered by this group?

Case Presentation vs Standard Behavioral Science Curricula

Several procedures were used to determine the answer to the first question. First, all case summaries of the sessions from May 1977 to May 1978 were examined, and only those which dealt with

physicians' presentations of difficult cases were included in the analysis. Of the 47 sessions during this time period, 33 of them (70 percent) were devoted to such presentations.

Given this sample, the content of each presentation was first noted and then categorized according to the major issue(s) with which the case dealt. It should be noted that the categories were not mutually exclusive: a single case presentation could be classified under several categories (eg, depression and family dynamics⁸). These general categories were then compared to general categories in the standard behavioral science curricula, obtained from current textbooks and reference sources in the field of family practice.

For the purposes of this study, four sources were employed (Conn, Rakel, and Johnson's 1973 *Family Practice*,³ Rakel's 1977 *Principles of Family Medicine*,⁵ Snodgrass's 1975 *Fundamentals of Family Practice*,⁴ and the Society of Teachers of Family Medicine's 1973 *Selected References in Family Medicine*)⁸. The standard behavioral science curricula were obtained by looking at the list of topics and issues covered under the section of each source entitled "Behavioral Sciences in Family Medicine." It was assumed that such lists of topics and issues would be representative of what educators feel should be part of the standard behavioral science curricula for family physicians. Table 1 shows an integrated list of these topics and issues, together with the number of Thursday Morning Group sessions devoted to each topic.

Group members did spontaneously bring up patients who cover the range of issues and topics ordinarily covered in standard behavioral science curricula. The only topics which were not dealt with during the course of the year included learning disorders in children and psychoses other than schizophrenia. In explanation of these omissions, one might speculate that even though family physicians do indeed come in contact with individuals suffering from such disorders, they might typically refer them to other health care providers (such as psychologists and/or psychiatrists) who deal specifically with such disorders. In fact, these two topics are considered as being of primary importance for the family physician by only one of the four sources.³

In addition to these standard topics and issues, group members also presented cases which dealt with issues not included on these lists. Numerous

case presentations considered the manner in which physicians interact with each other, as opposed to the more widely considered topic of physician-patient interactions. Four presentations dealt with specific conflicts between family physicians and other specialists. Three presentations generated discussion about the various roles a family physician sometimes plays with patients and how difficult it is for the same person to play more than one role, thereby acknowledging the way in which physicians working in the same setting can help each other when such situations arise. Other topics and issues presented included: (1) who is the patient, ie, is the individual who is presented as the patient really sick or just a scapegoat for familial pathology? (2) how does the family physician deal with patients who want only a limited contact for either themselves or their family, particularly in light of the notion that a family physician is committed to "whole person-whole family" care? (3) strategies of psychotherapy, eg, where to intervene when both the patient and the family physician are uncomfortable and when to stop if the family physician is unsure of the therapeutic goals; (4) the treatment and management of the individual who stutters; (5) how to deal with patients who refuse to stop smoking; and (6) the problem of an individual's freedom of choice to refuse or accept treatment for self and/or family.

Adequacy of Patient "Typologies" for Group Case Presentations

Various authors in recent years have been concerned with establishing "typologies" of patients whom physicians view as "difficult." Stephens⁶ feels that family practice residents have an almost universal bias against patients who are fat, poor, or ignorant. Groves⁷ describes four stereotypic groups of "hateful patients"—those with whom the physician has an occasional personality clash and, therefore, comes to dread—which include: (1) "dependent clingers," patients evoking the physician's aversion because their care requires "limits on expectations for an intense physician-patient relationship"; (2) "entitled demanders," patients who consider the physician as an "inexhaustible supply depot," thereby instilling him/her with the wish to "counter-attack" by rechanneling the patients' feelings of total entitlement to good medical care, rather than to un-

Table 1. Issues and Topics in Standard Behavioral Science Curricula and Number of Thursday Morning Group Meetings Devoted to Each Over the Course of One Year

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| 1. Physician-patient interaction | 33 |
| 2. Impact of illness on the family | 14 |
| 3. Organic vs psychological illness | 6 |
| 4. Relating to the psychiatric patient | 6 |
| 5. Depression | 5 |
| 6. Drug abuse | 5 |
| 7. The "at-risk" patient | 5 |
| 8. The terminally ill/death and dying | 5 |
| 9. Contraceptive counseling | 4 |
| 10. Interviewing techniques | 4 |
| 11. Ethical dimensions of behavior | 3 |
| 12. Marriage and family counseling | 3 |
| 13. Sexual counseling | 3 |
| 14. Psychopharmacologic agents | 2 |
| 15. The emotionally disturbed child | 2 |
| 16. Acute and chronic anxiety | 1 |
| 17. Alcoholism | 1 |
| 18. Schizophrenia | 1 |
| 19. Confusion in the sick or elderly | 1 |
| 20. Learning disorders | 0 |
| 21. Other psychoses | 0 |

realistic demands; (3) "manipulative help-rejecters," patients evoking depression in the physician since they unrelentingly feel that no regimen will help; and (4) "self-destructive deniers," patients who evoke feelings of malice in the physician since, due to their unconscious display of self-murderous behaviors, "their management requires the physician to lower Faustian expectations of delivering perfect care."

In light of these characterizations, the second question posed in this paper is: To what extent are the generalizations about patient "typologies," such as the above, adequate in dealing with the actual cases presented by members of the Thursday Morning Group? In order to answer this question, all case presentations used in the first analysis were also categorized, by a single individual, according to these two sets of typologies. In an attempt to increase the reliability of these categorizations, a random sample of the case presentations was also scored by two independent judges. High reliability scores among the three raters were obtained. This analysis led to several important considerations.

First, given the nature of a significant proportion of the physicians' patient population, which

serves a family health center in a lower socioeconomic neighborhood where the majority of patients are poor and a significant number are not well educated, Stephens' typologies did not appear to be helpful in understanding the physicians' reasons for presenting such patients.

Secondly, even though Groves' typologies characterized a large percentage (66 percent) of the patients presented (21 percent were characterized as "dependent clingers," 12 percent as "entitled demanders," 15 percent as "manipulative help-rejecters," and 18 percent as "self-destructive deniers"), several problems with his classification system became evident through this analysis: (1) The typologies were not mutually exclusive, as all patients did not fall neatly into one or another of his categories. For example, 9 percent of the patients were classified as both "entitled demanders" and "manipulative help-rejecters." (2) The typologies did not appear to be exhaustive, as some patients (33 percent) did not fall into any of his categories, yet they were still considered to be extremely "difficult" and "emotion-evoking" patients by members of the group. (3) Since the typologies characterize individual patients, they were not entirely appropriate for the 12 percent of case presentations which dealt with the management of difficult families. Although one or more family members might be characterized by one of these typologies, the typologies were not adequate in capturing the nature of familial interactions. Therefore, in light of the family physician's emphasis on treatment of the "whole patient-whole family," one might question whether family typologies, such as those presented by Minuchin,⁹ would be more helpful for looking at and understanding the case presentations of family physicians.

Physician Variables

During the course of the group sessions, it became clear that individuals had different ideas about what information was needed to understand the patients. There appeared to be three types of information that physicians employed: (1) that related solely to the presenting patient, eg, the patient's biological signs and symptoms—external to the physician; (2) that related to the interpersonal realm between patient and physician, eg, the physician's own thoughts and feelings about how he/she related to the patient, and vice versa; and

(3) that which explicitly sought to determine what the patient thinks/feels about himself/herself, ie, with respect to the course of the presenting signs and symptoms, and about others in the family group, as well as, conversely, what the others in the family think/feel about the patient. After some discussion, it was generally agreed that the latter type of information, whereby the entire family was considered to be the appropriate "unit of analysis," was the most helpful in arriving at an understanding of the patient.

Therefore, in an attempt to look at what the family physicians of this group considered to be pertinent information with respect to their actual cases, a questionnaire assessing reasons for case presentations at the group meetings was distributed to all group members. A comprehensive list of these reasons is presented in Table 2. The majority of cases appeared to be presented for clarification of issues relating to physician-patient interactions and physician-patient's family interactions. This suggests that family physicians are, in fact, concerned with treating the "whole person" rather than simply focusing on circumscribed aspects of physical illness.

Educational Implications

Since the Thursday Morning Group is comprised of family physicians who have direct or indirect relationships to the teaching of residents and students, there has been an attempt to see if the group contributes to teaching skills. There seems to be a fundamental assumption by members of the group that difficulties which a physician has dealing with various aspects of the physician-patient relationship often mirror difficulties encountered by the physician in a teaching relationship with a student or a resident. It is the relationship between physician and patient that is the focus of the discussion rather than the personality of the individual physician or patient, as might be the case in a more traditional psychoanalytic approach to a given problem situation. Thus, physicians having trouble in dealing with aggressive patients who place forceful demands on them may well have difficulty in relating to aggressive residents in a teaching situation. If these physicians gain skills from the group in dealing with aggressive patients, then they might similarly gain skills in teaching aggressive residents. This "mirroring" phenomenon using the physician-

Table 2. Physicians' Reasons for Case Presentations**A. Patient's Signs and Symptoms**

1. How to deal with an individual's depression
2. How to deal with patients' smoking behavior
3. How to deal with patients' seeming addiction to narcotics

B. Physician-Patient Interaction

1. Physicians' feelings of being manipulated by a patient and needing advice on how to deal with patient
2. Unusual nature of patient's chief complaint and making the physician feel uncomfortable during physician-patient interactions
3. Physicians' frustration when patient does not follow advice; physician needs advice for future physician-patient interactions concerning what the patient wants from the physician
4. Physicians' frustration and anger stemming from dealings with consultants, and how this affects the physician-patient interaction
5. Uncertainty about the physician's role in interactions with patients, eg, is this a therapeutic relationship? is the patient being "dependent" upon the physician?
6. How to deal with patients' anger at physicians
7. Countertransference issues and the need for "supervision" which involves the physician's own personality structure
8. The dilemma between "personal" and "professional" roles, or how to be a good friend and a good physician at the same time

C. Physician-Patient's Family Interactions

1. How to deal with one or more of a patient's family members who have goals that are antithetical to the goals of the patient, eg, family members' resistance to treatment
2. Discussion of inherited traits vs familial interactions as a cause for psychosomatic symptoms
3. Discussion of how three family physicians worked together to treat one extended family with respect to interactions on these planes: patient-patient, patient-physician, and physician-physician
4. How to deal with the patient who fears that a hereditary trait might have been transmitted to the offspring
5. The dilemma between "personal" and "professional" roles, eg, anxiety about treating a colleague and friend's son; effect of a patient's vocal, negative attitudes towards the Health Center on both the patient's and the physician's families

patient relationship as the fundamental source of analyzing and learning about clinical and educational interactions is, the authors feel, an important principle of family medicine education.

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