Family Practice Grand Rounds

The Clinical Social Science Conference in Biopsychosocial Teaching

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The emphasis on the biomedical model, which has served the medical profession well during the post-Flexnerian period, has been questioned for many years; however, the individuals who pioneered recommendations for change appeared to be ahead of their time.[1-3] Today, the proponents for a new medical model,[4-6] which brings into balance the biomedical and sociocultural sciences in patient care, seem to have found an accepting audience in the primary care specialties. Family practice, in particular, with its stated goal of comprehensive medicine,[7] claims that it needs a sociocultural curriculum that will meet the requirements of those who teach the student to view the whole patient within the context of family and community.[8,9]

The problems of educational imbalance in the training of a physician can be identified as early as the premedical period. Because the sociocultural sciences of anthropology, psychology, and sociology are recommended but not required by most medical schools for admission, premedical students tend to give low priority to these courses compared with the required "hard" sciences. In a study of three entering classes at the University of Washington, students who had two or fewer courses in the social sciences comprised 47.8 percent of the entering classes.

Another problem related to the design of the present medical education curriculum is that most courses that stress the complimentarity of the biological and social sciences are taught during the first and second years of medical school. Little is done during the medical student's clerkship years to apply to clinical problems the knowledge gained earlier in the behavioral and social sciences.

This paper will introduce the Clinical Social Science Conference, an educational method that has been found to integrate for the student and practicing physician the biomedical and sociocultural view of patient assessment and management.

Clinical Social Science Conference

In the fall of 1977, a monthly conference was initiated at the University Hospital's Family Medical Center at the University of Washington in Seattle. The goal of the conference was to establish an educational program that would permit attendees to learn through clinical case presentation that psychological, social, and cultural variables influence both the manifestation and management of clinical problems. The conference coordinators—physicians and social scientists—from the Department of Family Medicine, the Department of Psychiatry and Behavioral Sciences, and the School of Nursing aimed to highlight problems related to dysfunction of family and social support systems. They also sought to clarify misunderstandings related to the patient's health seeking behavior and cultural health beliefs.[5]

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Table 1. Illness Problems Identified During Clinical Social Science Conferences

Illness Problems	Examples
1. Maladaptive coping responses	Denial Passive-hostile behavior Shopping for doctors Suicide attempt
2. Inappropriate response to social/role change	Regression Somatization
3. Inappropriate resort to sick role and illness behavior	Chronic pain supported by secondary gain Drug abuse Factitious illness and management
4. Conflict between patient/family and practitioner regarding the cause, course, or outcome of sickness	Physician giving up in the case of terminal disease, patient feeling given up
5. Conflict in cultural values concerning treatment styles between ethnic patients and practitioners (patient's explanatory model in conflict with that of physician)	Patient's desire to be involved in non-traditional forms of therapy, such as acupuncture, back manipulation, and Christian Science
6. Conflict in cultural values concerning interpersonal etiquette between ethnic patients and practitioners	Some Asian patients feeling that it is inappropriate to maintain eye contact with the physician
7. Transference and counter-transference in the physican-patient or physician-family relationship	Physician having to deal with patient's own feelings of anger, inadequacy, frustration, or sexual attraction
8. Lack of compliance with a therapeutic regimen	Due to physician's failure to communicate outcome of treatment, patient's inability to clarify fears, hospital's environment producing restrictions in conflict with patient's lifestyle
9. Family dysfunction	As a consequence of the stresses induced by sickness, and absence of resources, family members withdrew or became symptomatic
10. Communication conflict between physician and patient/family	Due to language barrier, physician's authoritarian style, or physician's exclusive use of biomedical model to explain problems

The need for clinicians to recognize the co-existence of disease and illness problems in patient care was the conference's central goal. Disease problems were defined as the biological abnormalities underlying sickness, while illness problems (Table 1) were defined as the stresses that result from the way the patient (and members of the patient's family and social network) perceive, label, evaluate, and respond to symptoms of sickness.[10]

The Clinical Social Science Conference consists of three meetings—a pre-conference assessment of the case to be presented, a pre-conference patient interview by one of the conference coordinators, and a 1 1/2 hour conference.

At the pre-conference assessment of the case to be presented, the patient's biomedical status is first reviewed. Sociocultural information that will allow formulation of the patient's illness problems is then reported. The conference coordinators then establish the patient's illness problems that will be highlighted at the conference. For example, some cases feature problems of family dysfunction while others are keyed to a discussion of social support systems, somatization, or cultural health belief systems.

Having identified the focus for the conference, the coordinators are then assigned the tasks of conference chairperson, patient interviewer, or case discusser. The chairperson is responsible for the case introduction and summarization. Special emphasis during summarization is given to the integration of psychosocial and biomedical approaches in a concrete, practical management plan. It is felt that the identification of psychosocial problems has little significance to a practicing physician if the information cannot be used in a meaningful way to assist in patient care.

The purpose of the pre-conference interview of the patient is to obtain the data base needed to confirm the patient's sociocultural problems. This knowledge facilitates the 15-minute patient interview during the Clinical Social Science Conference. It allows the conference interviewer to focus on the critical problems.

The format of the Clinical Social Science Conference includes: (1) a basic biomedical case presentation by the attending physician(s); (2) a 15-minute interview of the patient, highlighting psychosocial issues; (3) a discussion of illness problems by conference coordinators; (4) audience questions and responses; and finally, (5) a summation of the case that indicates the ways that the resolution of both the patient's illness and disease problems may be effectively managed.

The following case is chosen as an example of a patient whose disease problem (cervical degenerative arthritis) was influenced by illness problems that related to her cultural heritage, her family situation, and certain stressful life events. In the future, cases will be reported that feature more profound family dysfunction, somatization, health belief conflicts, resource depletion, and pathological coping.

Case Presentation

DR. C. KENT SMITH *(Attending physician, Department of Family Medicine):* Mrs. K. is a 46-year-old Japanese-American mother of three teenage boys who has worked as a research technician for the past 16 years.

The patient's chief complaint is neck pain of three years' duration. Her initial care was at another health care facility. Cervical x-ray studies revealed slight spondylolisthesis of C5-6 and mild generalized cervical degenerative joint disease. Therapy included aspirin, phenylbutazone, and a trial with steroids. The patient was hospitalized briefly to introduce cervical traction that was continued at home. She claimed no improvement from this therapy. According to the patient, her physicians (including a neurosurgical consultant) informed her that she must learn to live with her condition. Mrs. K. was unwilling to accept this philosophy and switched her care to the University of Washington Family Medical Center (FMC).

Mrs. K. claims that although she is able to participate in some housework, she is unable to work in her garden or to ski. The communication from the patient's initial physicians included the comment that the pain the patient reported was excessive for the degree of pathology evident in the x-ray study. There is no known history of trauma. However, the onset of her symptoms is associated with some stress. These stresses will be clarified during the interview and discussion period.

Interview With Mrs. K.

DR. NOEL J. CHRISMAN *(Medical anthropologist, School of Nursing):* Thank you very much for coming. I'll try to take about ten minutes and we'll cover some things that we talked about yesterday (pre-conference interview). You came in July to the FMC to see Dr. Smith. At that time you were bothered by some neck pain. Can you tell us when that pain started?

MRS. K.: Almost three years now.

DR. CHRISMAN: Do you remember any circumstances in your life that were going on at the

same time as the neck pain?

MRS. K.: Well, I had moved, I had a brother-in-law come over. We were not in a new house, so we had to paint it.

DR. CHRISMAN: You are a research associate. You did work with baby baboons. What happened with that baboon that you remember working with at the onset of your pain?

MRS. K.: We have to train and then care for and do research on them. Then it is necessary to sacrifice the animal to dissect and weigh organs. Quite a stress. I had become attached to the baboon.

DR. CHRISMAN: So you've described two or three areas of stress in your life about that same time—the move, a family visit from Japan, and some stressful events on your job surrounding the killing and dissecting of a baboon. Once the neck pain had started, what did you do about it?

MRS. K.: First, I cry for my husband every night. It was a stress to work for eight hours. I have to have a massage every day. Then I could not stand it any more so I went to the doctors.

DR. CHRISMAN: That was the other health care facility.

MRS. K.: Yes. Then I got steroid shots a couple of times. That didn't ease my pain. Then I have to take eight tablets a day. Wasn't getting better.

DR. CHRISMAN: Did the physician at the other health facility prescribe any aspirin?

MRS. K.: Yes. He sent me to a neurosurgeon where I had x-rays, then I had neck traction and massage. Twice a day and twice a week for about six months or so I got better relief. End of the day it was the same thing. I used the heat pad every night, then it continued for two years.

DR. CHRISMAN: How long had you been going to the other health facility before you started going to a Chinese herb doctor?

MRS. K.: Year and a half maybe. I took ginseng tea for a year or so, I went to see a Chinese herb doctor where I got special kind of mixture of herbs. He said if my entire body circulation better then pain is gone. So got the Chinese herbs once every month—$15 for package. After one month you may get results. But I see no results. It took about two months. So he gave me acupinch—in my back and my shoulder. It bruise my back and shoulder. Didn't do any good. Right now I am doing acupuncture—it doesn't give me scar and looks like it is helping a little bit.

DR. CHRISMAN: Acupinch, which hurts and leaves a bruise, didn't seem to do any good. Acupuncture you tried twice and that helped you a little bit. But you haven't done that recently.

MRS. K.: I hate to ask my friend because he is not licensed. He does for favor. I hate to go back. I have to go to licensed one.

DR. CHRISMAN: Acupuncture you see as being a good treatment yet part of what holds you back on that is the difficulty of financing it.

MRS. K.: I don't know how much you need—$20, $30 a session. I pay myself for acupuncture every month.

DR. CHRISMAN: And that has been doing a fair amount of good.

MRS. K.: Yes, but it is expensive.

DR. CHRISMAN: Aspirin you said you gave up. On your own you tried ginseng for about a year. And although that made you feel good it didn't do much for the pain.

MRS. K.: It helped my GI problem. I just can't afford to do it.

DR. CHRISMAN: Are there any other things that you either did in the past or are doing for this pain?

MRS. K.: I do exercise. Therapist office say this to do. Also I do heating pad and hot shower.

DR. CHRISMAN: What did the doctors at the other health facility say about your pain once they had tried four or five different things?

MRS. K.: After a year or so I made appointment with a neurosurgeon. He said nothing wrong with me, no nerve wise. He cannot do anything about it. So go back to Internal Medicine. Maybe they can do something.

DR. CHRISMAN: What do you think of it when someone says you just have to live with the pain?

MRS. K.: That's why I tried everything to help. It kind of depresses me not to be able to do things like skiing. If pain is gone then I feel much better and I feel like doing things.

DR. CHRISMAN: So from physicians you've had a lot of medical work-ups and a lot of good ideas that don't seem to help. Yet you weren't really willing to accept the notion that you have to live with it, especially if it keeps you from doing things you enjoy. You told me before you would like to have 80 percent of it gone and live with 20 percent that would allow you to do some of the things you enjoy.

MRS. K.: That's right.

DR. CHRISMAN: One of the things that came out in your earlier interview was that you weren't really sure what the name of the problem was, what the diagnosis is. Have you heard anything about what it's called?

MRS. K.: Osteoarthritis or something like that. Neurosurgeon said it is not great enough to cause this kind of trouble.

DR. CHRISMAN: What do you feel would be most helpful to you at this time?

MRS. K.: The acupuncture is helping me but it is very expensive. I would like some help.

DR. CHRISMAN: Thank you for meeting with us, Mrs. K. Dr. Smith will report to you our findings.

Commentary

DR. ARTHUR KLEINMAN *(Psychiatrist and medical anthropologist, Department of Psychiatry and Behavioral Sciences)*: The chronic complaint of pain not infrequently serves the dual purposes of communicating personal and social distress in a socially sanctioned somatic or medical idiom and therewith manipulating social relationships towards a desired end. In Mrs. K.'s case, there is not enough detail to confirm or refute this possibility. But it is plausible in organizing a therapeutic regimen for her to test this clinical hypothesis against what we learn about her and her social networks. For if psychosocial factors are contributing significantly to maintain her chronic pain behavior, then their identification is an essential step toward changing the social conditions supporting this maladaptive behavior.

In Japanese, Chinese, and many other ethnic groups, it is the norm for psychiatric problems to be culturally transformed into somatic ones. This is to say, individuals in these cultures learn to articulate potentially stigmatizing psychological problems in a sanctioned idiom of physical distress and "dis-ease." Somatic symptoms—not psychological ones—carry social efficacy. Chronic pain is a characteristic form of somatization. It is not easy to determine if this happened in Mrs. K.'s case, but it is a real possibility and therefore should be an essential part of further clinical assessment.

The evaluation of somatic complaints necessitates both a biomedical investigation of potential "disease" problems (ie, the underlying biological malfunctioning) and an ethnomedical or clinical social science assessment. This should include assessment of the meaning the chief symptoms and the life problems hold for a particular person in a particular situation. A quick method of assessing the psychosocial component of this work-up is to elicit the patient's explanatory model for the illness. This includes his or her beliefs about its cause, pathophysiology, expected course, and appropriate treatment. Together with elicitation of the particular significance of the illness (eg, threat, loss, gain), this clinical material gives the practitioner clues as to the functions the illness behavior may perform and the determinants maintaining it.[5,10]

In chronic pain patients, significant financial and/or psychosocial gain can play the major role in maintaining illness. Hence, it is crucial for clinicians to understand both personal and cultural aspects of gain in order to deal with this problem effectively. Finally, a complete understanding of the psychosocial aspects of a case requires evaluation of the patient's psychiatric status. This is because depression, anxiety, neurosis, hypochondriacal personality, hysteria, and other psychiatric disorders frequently present as somatic problems, especially among more traditionally oriented members of ethnic groups.

Rather than continue this general level of discussion, I hope that Drs. Smilkstein and Chrisman will comment on how such clinical social science concepts as illness problems, explanatory models, and the others I have reviewed might be applied more specifically to forge a better understanding of Mrs. K.'s problems and result in a culturally appropriate treatment plan. By the way, the fact that the patient seems to tell us so little about her personal life, and stays on a superficial level of communication is culturally determined. This presents a real problem for caregivers in eliciting relevant clinical data. The paucity of information in response to a question may cause the interviewer to give up and choose symptomatic treatment. This, we feel, is inappropriate and usually not helpful to the patient.

DR. CHRISMAN: Mrs. K. is an immigrant from Japan who has been in the United States for about 20 years. Frequently, health care providers view ethnic group membership as a homogeneous phenomenon. However, two significant variables contributing to the heterogeneity in any ethnic population are: (1) the number of years a first genera-

tion immigrant is a resident in the United States; and (2) the generational distance from the homeland if the person was born in the US. These two variables provide a rough indication of the degree to which the person is likely to maintain homeland cultural traits. Happily, the Japanese have provided us with terms for generational distance from Japan. The immigrant or pioneer group, migrating to the US from the late 1800s until 1924, are called *Issei*. Their second generation native born offspring are the *Nisei*, with *Sansei* (third) and *Yonsei* (fourth) following. Mrs. K. is an Issei, but because she is a recent immigrant, she is not a pioneer and was raised in Japan at a time in which Western medical practices were significantly integrated into the Japanese health care system. Thus, we expect and find a positive orientation toward Western medicine characteristic of her Nisei and Sansei age cohort.

From this perspective (Western), Mrs. K.'s health seeking pattern appears unremarkable. That is, the explanatory model for the neck pain included a stress related cause that she and her physician correlate with the onset of the problem. Her lay consultation process included her husband, to whom she also turned for support and treatment. When her attempts at family based care were not efficacious, she sought help from her initial provider. After a medical work-up, traction and massage were suggested and she continued with this regimen for more than a year. Simultaneously, however, she explored options based in Asian medicine: acupuncture, moxibustion, ginseng and a prescribed herbal tea, and acupinch. She thus engaged in the common Asian practice of consulting practitioners from two medical systems simultaneously, ie, dual use. The only efficacious treatment was acupuncture.

Mrs. K. visited the family medical center in order to receive a doctor's order for acupuncture. She hoped that this route to desired health care would allow her to obtain third party payment for the treatment. For the diagnosis and management of similar cases, family physicians should consider the following factors:

1. The clues of ethnicity: There is a great deal of heterogeneity of belief and practice in all ethnic groups. Sensitive and nonjudgmental interviewing about etiological and treatment beliefs can establish the pattern of past care seeking, and thus provide clues about cultural perspectives.

2. Although this pattern of dual use is common for the Chinese and slightly less common for other Asians, it is widely distributed across the American population. Understanding the patient's use and evaluation of non-physician treatments is helpful in designing a treatment regimen with which the patient will be most likely to comply.

3. With the increasing popularity of alternative health treatment programs among the public, physicians should be knowledgeable about these programs to advise on likely toxicities. Although rapport with the patient is enhanced through the approval of neutral or beneficial folk practices, harmful practices must be identified and condemned. It is essential to remember that these alternative practices are embedded within systems not based on Western biological thought, thus Western rationale for their exclusion will not always be understood or accepted.

DR. GABRIEL SMILKSTEIN *(Family physician, Department of Family Medicine):* The family issues in this case are so closely tied to the patient's cultural heritage that dissection, isolation, and display of family problems apart from her ethnicity are difficult. For today's discussion, it may suffice to review the impact of stressful life events on Mrs. K.'s family and note how these stressful events may be resolved. Mrs. K.'s stresses include a recent move to a new home, a visit from a relative, and the death of a research animal to which she had become attached.

A move is rarely a benign experience for a family, unless the move is made within the neighborhood. Family dysfunction frequently results from a loss of social and professional support groups that include friends, relatives, religious group members, dentists, doctors, lawyers, etc. The stress due to the loss experienced from a separation from a long-established social support system may be severe.

A visit from a relative had definite ethnic overtones in evaluating Mrs. K.'s stress. "We were not in a new house, so we had to paint." It would have been unthinkable for Mrs. K. to have accepted a brother into her home as a guest in a house that was less than perfect. Only the physician who was sensitive to ethnic issues would be aware of the intensity of stress that Mrs. K. experienced by the visit of a relative.

The death of the baby baboon was a stressful life event to which Mrs. K. might have adapted if

she had not had a series of other stresses which had depleted her resources. When resources are not adequate to meet a patient's life stresses, a state of anxiety is the usual consequence. This state has also been labeled a life crisis. If resources cannot be found within the family or extended social support system, a defense mechanism is chosen to protect the patient from the anxiety of the unresolved crisis.[11] In Mrs. K., the defense mechanism chosen was somatization. It is likely that based on the ethnic illness behavior described by Drs. Kleinman and Chrisman, the patient would have found little family support for her needs if she were to express her problems as emotional distress or anxiety.

Audience Question

QUESTION: As a practitioner, I have difficulty identifying those patients who require a psychosocial work-up. What are the clues in Mrs. K.'s case that told you that a biomedical program would be inadequate?

DR. SMILKSTEIN: The physician who is sensitive to the role that anxiety plays in illness problems would have picked up a number of clues from Mrs. K. The ones that come to mind are: disability and discomfort that exceeded that which might have been expected from her objective (x-ray) findings; high utilization of the health care system; and some measure of doctor "shopping." Other clues that suggest that sociocultural problems should be addressed are: non-compliance with therapeutic regimens, "laundry-lists" of symptoms, excessive use of analgesics and rest, and symptoms of depression.

Summary and Patient Care Recommendations in the Case Presented

Disease Problems

1. Cervical spondylolisthesis, C5-6, mild
2. Cervical degenerative joint disease, mild

Illness Problems

1. Conflict between patient and physician regarding sickness outcome
2. Conflict between patient and physician regarding use of cultural medicine (non-recognition by physician)
3. Family dysfunction (patient somatization) regarding stressful life events and depletion of family resources

DR. KLEINMAN: To summarize, we simply do not know enough about Mrs. K. at this point to complete her assessment plan. She denied significant dysphoria, and she complained neither of depression nor of symptoms associated with the other frequently somatized psychiatric problems. It is most likely that her illness behavior, primarily somatization, is related to family and/or job problems; however, more information is needed to confirm this assumption. This approach will almost certainly involve the negotiation of a new therapeutic contract between the primary care physician and the patient. The contract should address her illness problems and legitimatizing cultural treatment, namely acupuncture.

Addendum: Acupuncture was authorized by the primary care physician. The physician and patient continued a dialogue regarding home and work problems. Three months after the conference the patient reported that she was almost entirely pain free.

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