The Family Physician as a "Therapeutic Instrument"

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The doctor-patient relationship is the matrix of the family physician's diagnostic-therapeutic activity. To enhance the curative potential inherent in this relationship, the physician has to be able to make contact with the *person* in the patient. To achieve this, the physician must develop his potential for empathic observation, empathic listening, and introspective self-awareness. The use of these skills in a non-judgmental, non-condemning, and non-manipulative climate creates an optimum therapeutic setting.

Rather than focusing upon the body of knowledge available in the behavioral sciences, or upon the pursuit of learning "psychiatry" or "psychotherapy," the family physician should first develop his own personal skills. He should then apply them to his own patients, in his own setting, in order to discover the therapeutic approaches appropriate to his patients and their problems. The psychiatrist, psychologist, or any other behavioral scientist can be most helpful to the family physician if he is prepared to aid him in his own discoveries rather than attempt to teach him the accumulated knowledge from his own field.

Family medicine cannot and should not be sharply defined a priori. It should be allowed to evolve in the ecologic system in which it operates, and its boundaries should ultimately be defined in relation to the specific tasks set before its practitioners and their individual capacities to deal with them.

If we accept this empirical approach to the development of the field and to the job description, it follows that we cannot describe exactly just how much and which branches of medicine and surgery the family physician should master. The same applies to the behavioral sciences and especially to psychiatry. Family medicine, although using knowledge and techniques from all branches of medicine and surgery, is not simply a selected conglomerate of them. It is, perhaps more than anything else, a return to a more personalized, continuing, direct, comprehensive, primary care of whole families and their individual members with a distinct twofold aim: to turn intimate knowledge of the whole family to diagnostic and therapeutic advantage and, when possible, into preventive intervention. This paper will focus on the overall training and education of the family physician required as preparation to provide this kind of care.

The Personal Skills of the Practitioner

It is to be assumed that a physician who chooses the field of family medicine is not primarily *illness*-oriented or *technique*-oriented, but *person*-oriented. It is the *person* in the patient that he will want to be able to make contact with, in order to understand, treat, and prevent *illness*. This particular motivation seems to me to be the single most important factor in determining the appropriateness of a physician's choice of family medicine as his field of practice. Given this kind of motivation, sensitivity to and knowledge about the sociocultural and historical contexts of the individual and the family will aid the physician in making effective contact with the person in his patients. It is this contact that will forge a doctor-patient relationship and carry the essential ingredients of the curative factors which can be mobilized in such a unique relationship. Some of the details of such a therapeutic relationship will be delineated here.

What do we mean by "making contact with the person in the patient" and by "the curative factors in a therapeutic doctor-patient relationship"? Simply put, it is our varying ability to put ourselves into the shoes of another, through temporary identification with him, that permits us the only kind of firsthand knowledge and understanding of his inner life we can ever obtain. To empathize with the feelings, concerns, and predicaments of another, to view his world from within, that is, from his own vantage point, is the surest way to make therapeutic contact with the person in the patient.

The capacity to make such contacts through what we call *empathic observations and empathic listening*, coupled with *introspective self-awareness*, is potentially present in all of us. To be used professionally, this potentiality has to be transformed into a safe and secure actuality. Thus, these empathic modes of observation, listening, and introspection are crucial personal skills for the practitioner. These are some of the key functions of the physician as a "therapeutic instrument" or, expressed differently, some of the therapeutic ingredients of the drug "doctor."

The manner in which the physician's *professional self* develops and functions as a therapeutic instrument should be the chief target of his basic training and education. The therapeutic ingredients, the indications, contraindications, and side effects of the drug "doctor," to be the core elements of his experiences in his residency.

The Acquisition of Therapeutic Attitudes and Methods

In this broad statement of the philosophy of training and education for the family physician, we should

This paper has been adapted from a presentation at the 1976 Annual Workshop for Directors of Family Practice Residency Programs on June 8, 1976, in Kansas City, Missouri. Requests for reprints should be addressed to Dr. Paul H. Ornstein, Department of Psychiatry, University of Cincinnati Medical Center, 231 Bethesda Avenue, Cincinnati, Ohio 45267.

not make the arbitrary separation between the organic and the psychologic, but address the unity of the person, mindful of both dimensions.

It is the thesis of this paper, therefore, that a therapeutic attitude based upon an empathic understanding of the patient's presenting problems will best serve as a point of departure for an appropriate diagnosis and treatment.

It is the non-judgmental, non-condemning, and non-manipulative atmosphere between doctor and patient that will permit the most open, and therefore, the diagnostically and therapeutically most meaningful communication between them. Wherever the diagnostic-therapeutic accent might eventually be found in a given patient – on the organic, on the psychologic, or on the interaction of both – the attitude just described will safeguard the physician's focus upon the patient as a person with a past, and as a member of his family, and of his larger sociocultural environment.

Only in relation to his own patients – not those on the psychiatric wards or in outpatient clinics – can the family physician acquire the diagnostic-therapeutic attitudes and methods necessary and appropriate to his own practice. It is a mode of relating to his patients and a way of thinking about them, on the basis of what transpires in these relationships, that has to precede his acquisition of useful cognitive knowledge of aspects of the behavioral sciences. Putting the cart before the horse, that is, attempting first to teach the physician what the behavioral scientists know about his patients, before making him cognizant of his personal skills and rendering them available for professional use, seems to me to be the most serious pedagogic obstacle to the practice of a truly "wholistic" family medicine. It is impossible to translate such textbook knowledge into immediately effective patient care. First, it has to become part of the physician's personal knowledge, that is, a meaningful part of his own personality. If it remains a foreign body, grafted onto his personality, it will only be a technique at best, which he will attempt to apply to specific symptoms, syndromes, or behavior patterns in his patients – and it will not turn into a capacity to make contact with their inner world. A focus upon the family practice resident as a developing "therapeutic instrument" demands a training and educational experience that will transform him into a sensitive, empathically observing, listening, and introspecting person.

Such a personality change is a necessary prerequisite for the three steps through which the family physician may ultimately turn basic therapeutic attitudes into specific therapeutic methods:

1. He should *accept* the patient's presenting problems and behavior without a judgmental or condemning attitude by creating a climate of mutual trust, in which an optimum degree of freedom of communication may develop between patient and doctor.

2. He should *understand* the meaning, origins, or history of such symptoms or behavior, and the purpose they serve or the role they play in the patient's emotional life.

3. He should *communicate* such understanding to the patient, tactfully, in appropriate doses at the appropriate times, so that the patient, too, may understand the meaning and purpose of his own behavior and symptoms.

Acceptance, understanding, and the *communication* of this understanding to the patient may then evolve into a progressively more specific treatment method by the family physician. The climate of empathic acceptance alone may already be generally beneficial and may enhance the effectiveness of any specific treatment modality. Adding the attempts at understanding the meaning and origin of the patient's problems, and their effect upon his current functioning and family relationships, will lead the physician to an ever broadening and deepening perspective from which his attitudes and interventions may have a greater impact upon his patients. The family physician can then progress from this stage to the point of finding tactful and emotionally meaningful ways of communicating his understanding to the patient, so that the latter may use this knowledge to his own advantage. This third step of making explicit what is often implicitly and non-verbally understood between doctor and patient, significantly enhances the therapeutic use of the doctor-patient relationship for both participants.

If the desirability and usefulness of the therapeutic attitudes and methods just described are accepted, some definite pedagogic implications follow and should now be examined.

The Expansion of Therapeutic Skills

The pedagogic focus in the training and education of the family practice resident may start with the assumption that self-selection brings physicians into this field whose interest in the person of the patient is matched by a good potential for empathic observation, listening, introspective self-reflection, and communication. These skills can then best be deepened and more firmly anchored for professional use by experiential learning provided in clinical case conferences and individual preceptorships.

The clinical case conference serves as an opportunity to discuss the resident's experiences with unselected patients under his care, to interview the patients in front of the participants, and to focus discussion on the three steps in the diagnostic-therapeutic process outlined earlier: acceptance, understanding, and communication.

We may also describe three overlapping steps in the conduct of the clinical case conference: (1) Initially, no attempt should be made to offer the formulations available to the specialist-conference leader. Instead, the participants should be aided in arriving at a collective understanding of their patients, on the basis of what is available to them from their own life experiences and, thus, from their own empathic-intuitive knowledge of people. The aim is to guide the residents to discover for themselves, from their actual interaction with their patients, the relevant data which may add up to a coherent, therapeutically useful understanding; (2) The primary focus upon diagnostic-therapeutic skills can then be supplemented by attempting to grasp cognitively how to use oneself as a therapeutic agent in the doctor-patient relationship; (3) When this step is sufficiently mastered, additional knowledge, accumulated in the various branches of the behavioral sciences, can be more meaningfully introduced to amplify the participants' personal knowledge.

The Relevance of Additional Knowledge

The question as to what is relevant

knowledge of the behavioral sciences for the family physician is a difficult one to answer. Only further joint clinical experience of the family physician, and representatives of the clinically oriented behavioral sciences, could arrive at an empirically testable, valid answer. It is this writer's view that the psychiatrist can be most useful, if he offers primarily his mode of approach, rather than the body of accumulated knowledge from his own field. The partnership between our respective fields should focus upon jointly discovering what emerges in the new setting. The psychiatrist will only learn about that via the primary experience of the family physician. He cannot pose as an a priori expert. We in psychiatry have to guard ourselves against the attempt at wholesale export of our theories and techniques into your field, since that is a much less demanding task for us and quite useless to you. You in family medicine will have to guard against accepting the all-too-easily available facile formulations we may offer, instead of helping you develop your own skills and relevant approaches to your own clinical problems. You will have to resist the attempts on our part to turn you into psychiatrists or psychotherapists, which is easier for us to do than to grapple with your problems afresh.

Experience tells us that the most useful additional knowledge, the kind that may turn into "personal knowledge" and thereby become more easily and quickly translatable into direct patient care, is acquired in the clinical case conferences and in individual preceptorships. Knowledge, added bit by bit as the clinical situation demands it, is knowledge sought and, therefore, more readily integrated. Without that demand, it often remains unusable.

Aiming at clinically relevant, experiential learning and supplementing this with knowledge not available from immediate experience, but relevant to it, will be the most significant way in which family physicians may be able to expand personal knowledge gained from their own life experiences and from those of their patients.

My central message is that the family physician need not become and should not become, a psychiatrist or psychotherapist. He need not and should not learn psychiatry or psychotherapy. Instead, he should develop his own personal skills and applying those to his own patients, in his own setting, he will discover the appropriate therapeutic approach to his patients and their problems.

It is from the understanding gained by him, from his own experience in treating his own patients, that he will derive maximum benefit for his patients, for himself, and for his field. To accomplish this, he should seek the counsel of those psychiatrists who are willing to form a partnership with him in order to embark on joint discoveries in the family practice setting and not the counsel of those who are merely willing to teach him the knowledge they gained in their own field.

Suggested Reading

1. Balint M: The Doctor, His Patient and The Illness, ed 2. London, Pitman Medical Publishing Co, 1964
2. Balint M, Balint E: Psychotherapeutic Techniques in Medicine. London, Tavistock Publications, 1961
3. Ornstein PH: What is and what is not psychotherapy? Dis Nerv Syst 29:118-123, 1968
4. Ornstein PH, Goldberg A: Psychoanalysis and medicine: I. Contributions to psychiatry, psychosomatic medicine and medical psychology. Dis Nerv Syst 34: 143-177, 1973
5. Ornstein PH, Goldberg A: Psychoanalysis and medicine: II. Contributions to the psychology of medical practice. Dis Nerv Syst 34: 278-283, 1973