

The Unique Contribution of Behavioral Scientists to Medical Education: The Top Ten Competencies

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**THE UNIQUE CONTRIBUTION OF BEHAVIORAL
SCIENTISTS TO MEDICAL EDUCATION:
THE TOP TEN COMPETENCIES***

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ABSTRACT

Understandably, the focus of most physicians is primarily on the biomedical—What is this disease or injury? Behavioral scientists from various disciplines in medical education generally have a broader approach—Who is this person with these symptoms and what is their story? Since behavioral scientists are often alone among U.S. residency faculty, physicians may fail to recognize the value of their approach to medical resident training. This review identifies and describes the top areas of expertise that behavioral scientists bring to medical education and how their training prepares them to think differently than other medical educators. In the course of identifying each competency, this review will emphasize the ways in which their skills and techniques are the origin of subtle impact in their teaching encounters, explore ways of targeting that impact, and discuss examples of this impact.

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Key Words: medical education, residency education, behavioral scientist identity, behavioral science tools, behavioral science strategies, biopsychosocial model

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INTRODUCTION

By virtue of their training and orientation, behavioral scientists from any discipline (medicine, psychology, psychiatry, social work, nursing, communication, anthropology, etc.) think differently than many family physician educators. By definition, a behavioral science educator is any provider who has training in the behavioral sciences and uses a biopsychosocial approach to patient care. Too often, physicians (and others) who use a biopsychosocial approach take their unique contribution for granted—“. . . *that's just the way we think.*” For many behavioral scientists, this uniqueness may be undervalued. Additionally, many medical trainees are primarily anxious about their ability to master sufficient medical knowledge and skills to perform adequately after graduation. The subtleties of physician-patient relationships and self-awareness can become secondary to proper diagnosis and treatment recommendations. A true biopsychosocial approach thus becomes a casualty.

While medical knowledge is regularly updated, everything residents learn about relationships with patients and about themselves is relevant the rest of their careers. This is the importance of the behavioral scientist's contribution during residency training. This is in marked contrast to the European-influenced medical education culture that emphasizes psychosomatic medicine in training and regular Balint groups throughout training and practice.

GOALS AND OBJECTIVES

In most U.S. residencies, behavioral scientists typically have little support in achieving their aims. Usually, one faculty is responsible to structure and deliver the behavioral science curriculum. Although the behavioral scientist may have a number of allies, being alone can create a sense of isolation. It is, therefore, important for residency programs to develop a greater awareness of what a biopsychosocial approach can offer medical residency programs. This can result in a clear understanding of the power, value, and impact of these tools, skills, and perspectives.

Finally, this review of the behavioral scientist's contributions to medical education will clarify the multidimensional strengths that contribute to the behavioral scientist's identity, and help behavioral scientists to create their own personal development plan.

UNIQUE CONTRIBUTIONS

This following list captures some unique contributions that behavioral scientists bring to medical education and healthcare.

#1: Emotional Intelligence

Behavioral scientists are emotion experts. Many physicians do not go “there.” “Opening the door” on a patient’s emotional life can be overwhelming and anxiety-provoking to a physician, in addition to being time consuming. Many physicians have not been trained or do not feel sufficiently confident to use listening and time management tools to respectfully respond in the limited amount of time they have in patient encounters. In contrast, behavioral scientists specialize in dealing with emotions.

A patient’s emotional reactivity to physical symptoms may totally negate the value of logic in understanding their medical condition, diagnosis, and prognosis. The patient’s emotions—and possibly the physician’s emotional reaction to the patient—will render useless all logical discussion [1]. The success of the physician-patient encounter will depend on the physician’s comfort and capability to address the patient’s emotional reactions. Goleman [2] led an entire industry in understanding emotional intelligence. Of particular importance is the identification of the components of emotional intelligence. Dividing this larger concept into its components of self-awareness, self-management, social skills, empathy, and motivation helps to clarify the complexity of the larger frame and focuses teaching and learning into manageable constructs.

Essentially, emotional arithmetic can describe the benefits of sharing emotional experiences. The impact of sharing positive emotional experiences with others who care is usually multiplied after this sharing—the joy is increased. Conversely, the impact of sharing negative emotional experiences divides the burden—more shoulders help to carry the emotion. Verbally sharing any and all emotional experiences is cathartic and supportive. Finally, one’s emotional vulnerability is the doorway to our humanity and the glue of relationships. When patients are emotionally struggling with health concerns and are willing to share those concerns to an attentive listener, they are generally the most genuine, authentic, and approachable. Behavioral scientists help physicians incorporate emotional intelligence into their practice.

#2: Listening

Behavioral scientists are listening specialists. Research has demonstrated that the typical patient experience includes an interruption from the physician within 16 seconds [3]. The pressure to diagnose and treat medical conditions in a brief amount of time contributes to the false impression of insufficient time. Further, physicians’ needs for a concrete result and a tangible product as evidence of his/her work devalues full listening to the patient’s story which can validate their experience of their symptoms. Listening is a treatment modality that may not be recognized by some physicians as procedure of choice or as a reimbursable intervention.

The counseling profession is anchored by high quality listening; 93,000 psychologists make their living based on their listening skills [4]. The most technologically primitive tribes had shamanic healers who were deep listeners [5]. These skills are no less important for physicians.

All of the benefits of listening to patients can be experienced by residents or attending physicians when they have an opportunity to share their experiences with each other in either the informal or formal settings of support groups or Balint group processes facilitated by trained leaders. It may be sufficient to simply reflect colleagues' emotional reactions to demonstrate the value of listening. A wider use of this "procedure" can impact the culture of an entire department or program. Examples include any of a variety of group reflective practices that are led by a behavioral scientist.

#3: Language and Thought

Language is a communication tool, and the degree of successful communication depends on one's ability to use it. Language allows us to talk about past, current, or future events and to discuss people or places that are not physically present. Without language, we would be limited to communication only about the present moment.

Language also communicates subtle messages about culture which are not always translated accurately. When Spanish-speaking patients know they will be seeing their Spanish-speaking doctor, their demeanor is palpably different [6]. Fadiman's report [7] about the tragic events surrounding the efforts of a Hmong family to get healthcare for their child documents the severe limitations of translation. In our increasingly complex and multicultural societies, cultural anthropology's focus on the relationship between language, thought, and communication teaches us essential tools for culturally responsible medical care [8]. Understanding cultural needs is far greater than translating words into another language.

Language influences not only how we think, but how we relate, what we focus on, and how we manage miscommunication and misunderstandings. Facility with language helps us work with emotions (emotional vocabulary), engage each patient as a whole person rather than as their disease or impairment [9], manage expectations (make the implicit physician-patient contract explicit), help expand a patient's perspective (reframes, metaphors), and helps distinguish intent from impact [10].

Behavioral scientists' specific training in language and linguistics has wide application in primary care. It includes teaching patients an emotional vocabulary to help them understand their experiences, reframing fear to transform it into hope, and inquiring about and accommodating different cultural traditions among patients with different backgrounds. Some of the simplest linguistic interventions include providing a name for an emotion expressed by a patient, supplementing their emotional vocabulary, or reframing a crisis such as a new diagnosis of

diabetes to an opportunity to make important lifestyle changes. In addition, behavioral scientists extend their language skills to physician colleagues and trainees by teaching and modeling ways to verbally communicate shared meaning, empathy, and compassion.

#4: Boundaries

Boundary issues are ever-present in clinical encounters. “Hey Doc, OK if I call you John?” “Doc, can I have your cell number in case I need to talk to you?” “My husband needs a refill on his Percocet and his doc is out of town. Will you just send in a script to our pharmacy?” “Whoa, I didn’t expect such a young and pretty doc. Are you married?” How do physicians learn to respond to these requests? How do physicians feel about these requests? What is the impact of these and other requests on the doctor-patient relationship?

Boundaries are the guidelines that help everyone contain the components of relationships. They include the implicit (or explicit) nature of the guidelines we negotiate in all relationships. Boundaries can address questions about a physician’s and patient’s obligations and privileges. The topics that can be included are each person’s responsibilities, timeliness, fees and payment, formality or informality, access to appointments, consultations, and prescription refills. When boundaries are explicitly named and agreed upon, they serve to reduce the uncertainty or anxiety in new and developing professional relationships. Boundaries help to create realistic expectations, and the discussion about boundaries can enable more informed decisions. When physicians do not discuss boundaries, they are in relationships based on others’ expectations rather than on principles physicians would prefer to establish. The discussion of boundaries may not occur because it takes time or because of a lack of skill. When boundaries become a problem, the consequences of dysfunctional, improper, or convoluted relationships and compromised healthcare can be high.

The behavioral scientist’s attention to boundary issues helps to balance the resident’s focus between the medicine and the relationship. S/he is often the person who points out the potential dual relationships that occur when a residency’s staff, faculty members, and their families are patients of that program. Too often, there is no discussion about the dual roles or potential risks of possible negative outcomes. While there may be a sense of security about the availability of medical care, there tends to be little discussion about the loss of privacy or the personal boundaries that get crossed of necessity while providing good care. Due to extensive professional training in boundary issues, behavioral scientists are ideally equipped to facilitate this discussion and help to clarify these issues.

#5: Process

All human transactions operate on multiple levels simultaneously. One common frame to describe these levels is content vs. process. An example is the

difference between what I say or do and how I say or do it. The simplest interactions occur at a literal or content level—people say what they mean. Sometimes, there are hidden meanings or agendas, or multiple messages that may be known or unknown. Familiarity and comfort with process can be essential to solving the puzzle or unlocking the mystery embedded in communication that has this added dimension.

An example of a process issue is when a patient makes an appointment to assess her back pain; however, when asked about how she takes care of this pain, the patient says “I have tried everything, and nothing works.” If we understand what she has said as an expression of frustration and exasperation, we can explore other possibilities. Another patient describes a history of horrible physical and emotional abuse. However, her flat affect is in marked contrast to the story she presents. The content does not fit with the underlying emotionless presentation. In a third example, a patient declines every suggestion a physician makes to remedy a symptom; a shift in focus can lead to discussing a person’s difficulty accepting suggestions rather than the quality of the suggested solutions.

#6: Systems Thinking

In the simplest terms, the whole is more than the sum of its parts. Systems can refer to biological systems, ecological systems, family systems, and even hospital, department, or residency systems. There are key characteristics to consider in every system. Every time there is an addition to or a subtraction from the group, it becomes a new system, and when one person in a system changes their behavior, it impacts the entire system. Being aware of the group’s dynamics is part of observing group process.

All groups experience predictable stages in their formation as a group. These stages have been described as forming, storming, norming, and performing [11]. Initially, groups begin with introductions, air differences of opinion or compete for roles within the group, then try to set standards for how this group will function, and eventually settle in to work together. This process is smoother with a facilitator who is attentive to these stages and can assist the group in working out their struggles to get to achieve a functional team environment. Without the attentiveness of a knowledgeable facilitator, team work and medical care can be compromised. These dynamics occur in patient’s families and in the residency teams, and a behavioral scientist’s skills reduce tensions among groups of people and support communication around medical care.

#7: Behavioral Scientist’s Toolkit

There are a number of discrete structured tools that behavioral scientists have at their disposal to use in teaching medical practitioners about delivery of their services. Examples include BATHE [12], Johari Window [13], Myers Briggs [14], MBSR [15], Motivational Interviewing [16], Stages of Change [17], Crucial

Conversations [18], Balint groups [19], Journaling—55 Word Stories—Narrative Medicine [20], support groups, and Appreciative Inquiry [21]. Each one has a specific purpose with suggested structure and an intended outcome. Some tools are useful to increase self-awareness (Johari Window, Myers Briggs), while others have as their primary focus assisting patients to understand their readiness to make changes in their lifestyle that impact their health (Stages of Change, Motivational Interviewing).

Some tools are designed to help all physicians become more aware of their own thoughts and feelings about patient care and increase their awareness of how these internal experiences may impact patient care. Examples include Balint groups [19], semi-structured support groups, MegaClinic [22] which helps residents monitor their personal emotional response to a session full of challenging patients, or a Continuity Case Conference [23] which helps to track the changing nature of doctor-patient relationships and the impact that has on patient care.

#8: The Courage to Teach

In *The Courage to Teach*, Parker Palmer [24] says that “. . . teaching always occurs at the dangerous intersection of our personal and public lives.” Behavioral scientists have an understanding of the subtleties of teaching and the parallels to physician-patient relationships. Palmer is remarkable in his exploration of a teacher’s relationship with his/her subject matter, with learners, and with our challenges connecting the two. Some learners are eager and others are resistant, just as some patients are eager and others are resistant. Because teachers may be highly invested in their subject matter (e.g., the biopsychosocial model), and not all learners may appreciate the importance or significance of the subject, teachers may feel personally and professionally challenged. In addition, many educators understand the false dichotomies of the objective and the subjective; nothing is totally objective or totally subjective. However, there are risks of retreating to the extremes. In using very personal examples, educators risk feeling a sense of vulnerability that comes with learners’ indifference; if educators use totally impersonal examples, they disconnect from the patient experience and lose the inherent meaning of this work.

The many subtleties about the reciprocal relationships between knower and known, between what is taught and how it is taught, and between teacher and learner create opportunities for personal and professional growth. The power and value of group discussion to enhance education further emphasizes the wisdom of creating a cooperative community of learners. The educator’s work is with the group, helping them to center their learning around specific patients in order to create a focus from which to generalize. Teaching that is focused on specific patient cases helps keep residents connected to their goals of becoming healers and observing the impact of a biopsychosocial approach.

#9: Thinking Outside the Box

The combination of creativity and creative arts add a dimension to medical education that engages residents through methods that are both surprising and revealing. The use of art, drama, dance, music, or poetry opens residents up to experiencing and/or expressing the full human experience of illness or injury. Staying in the “box” yields a more didactic or literal approach to teaching. The result is a more literal set of answers that help physicians identify ailments or syndromes they have seen before and allows them to prescribe a direct treatment. “Outside the box” is more figurative, and the result is the ability to understand each patient’s own illness experience through their own personal and cultural lens. This will create the opportunity for more personal and meaningful conversations with patients. Physicians, in turn, will have more customized remedies for illness experiences and will deliver the remedy in a manner that will be uniquely tied to their patient’s own understanding of their illness.

Behavioral scientists have a well-documented history of using creative arts in medical education. Examples include inviting patients to share the poetry they write, or learning labs to examine and explore the meaning of the wide range of fine art that depicts scenes of illness, or even using play dough to depict pain and then explain to their cohort group their representations of what pain means to them. There is a wide range and varied styles of physician writing [25-27] about training experiences, about less than ideal patient outcomes, and about the heart- or gut-wrenching experiences that are integral to being a physician. These may actually be situations where words do fail us, and relying on “out of the box,” non-linear or non-traditional teaching methods are needed.

**#10: The Therapist (or Listener) in the Program
is the Program’s Therapist (or Listener)**

Because of their expertise in human behavior and well-developed listening skills, it is quite common for behavioral scientists in training programs to be approached by faculty, staff, and residents with personal problems. They may include problems they are having with other faculty or staff members, child rearing problems, problems resulting from a divorce, personal problems of anxiety or depression, or even substance overuse. It is crucial that the behavioral scientist be clear about their own boundaries as a helping professional for his/her colleagues.

The challenge of entering into the dual role of being a “therapist” and an evaluator or a therapist and a colleague is best managed by avoiding these dual roles. It is important to have a list of resources, including community therapists we trust, to refer members of one’s program when desired. It can be very flattering to be asked by a colleague or trainee to be a therapist for anyone in our program. However, the change in roles will create complications that may compromise the behavioral science educator’s core role as a faculty member.

A middle ground taken by some behavioral scientists is to become a psycho-educator. This approach includes providing stress management classes, teaching mindfulness meditation, or conducting a support group. In more intense situations, behavioral scientists have lead debriefing sessions after a traumatic event in the community, hospital, or office setting.

SUMMARY

Behavioral scientists of all professional backgrounds provide a unique contribution to the advancement of a biopsychosocial approach in U.S. medical education. It is crucial for behavioral scientists to recognize and highlight their competencies and perspective in order to support the advancement of a biopsychosocial method. It is also essential that behavioral scientists intentionally work to advance their competencies. While many of these competencies may appear to be inherent characteristics, professional development is a process of continuous self-assessment and refinement of knowledge and abilities across the professional lifespan.

REFERENCES

1. Kahneman D. *Thinking fast and slow*. New York, NY: Farrer, Strauss, & Giroux, 2011.
2. Goleman D. *Emotional intelligence*. New York, NY: Bantam Books, 1995.
3. Rhoades DR, McFarland KF, Finch WH, Johnson AO. Speaking and interruptions during primary care office visits. *Family Medicine* 2001;33(7):528-532.
4. Retrieved December 10, 2013 from <http://www.apa.org/support/about/psych/numbers-us.aspx#answer>
5. Dobkin del Rios M. What we can learn from Shamanic healing: Brief psychotherapy with Latino immigrant clients. *American Journal of Public Health* 2002;92(10):1576-1581.
6. Fernandez A, Shillinger D, Grumbach K, Rosenthal A, Stewart A, Wang F, Perez-Stable E. Physician language ability and cultural competence: An exploratory study of communication with Spanish-speaking patients. *Journal of General Internal Medicine* 2004;19(2):167-174.
7. Fadiman A. *The spirit catches you and you fall down*. New York, NY: Farrar, Strauss & Giroux, 1997.
8. Ring J, Nyquist J, Mitchell J. *Curriculum for culturally responsible healthcare: The step-by-step guide for cultural competence training*. Oxford, UK: Radcliffe, 2008.
9. Folkins J. The language used to describe individuals with disabilities, 1992. Retrieved December 14, 2013 from http://www.asha.org/publications/journals/submission/person_first/
10. Rosenberg M. *Nonviolent communication: A language of life*. Encinitas, CA: Puddle-dancer Press, 2003.
11. Tuckman B. Developmental sequence in small groups. *Psychological Bulletin* 1965;63(6):384-399.
12. Stuart M, Lieberman J. *The fifteen minute hour*. Westport, CT: Praeger, 1993.

13. Luft J, Ingram H. The Johari window: A graphic model of interpersonal awareness, in *The Proceedings of the Western Training Laboratory in Group Development*. Los Angeles, CA, 1955.
14. Myers IB, McCauley MH, Quenk N, Hammer A. *MBTI handbook: A guide to the development and use of the Myers-Briggs Type Indicator* (3rd ed.). Consulting Psychologists Press, 1998.
15. Kabat-Zinn J. *Full catastrophe living: Using the wisdom of your body and mind to face stress pain and illness*. New York, NY: Dell Publishing, 1990.
16. Miller WR, Rollnick S. *Motivational interviewing: Preparing people to change*. New York, NY: Guilford Press, 2002.
17. Prochaska JO, DiClemente CC. *The transtheoretical approach: Toward a systematic eclectic framework*. Homewood, IL: Dow Jones Irwin, 1984.
18. Patterson K, Grenny J, McMillan R, Switsler A. *Crucial conversations: Tools for talking when the stakes are high*. New York, NY: McGraw Hill Professional, 2012.
19. Balint M. *The doctor, his patient, and the illness*. New York, NY: International Universities Press, 1957.
20. Charon R. Narrative medicine: A model for empathy, reflection profession and trust. *Journal of the American Medical Association* 2001;286(15):1897-1902.
21. Hammond S. *The thin book of appreciative inquiry* (3rd ed.). Plano, TX: Thin Book Publishing, 2013.
22. Sternlieb J. Teaching housekeeping: Learning to manage the emotional impact of patient care. *Families, Systems and Health* 2008;26:356-364.
23. Sternlieb J. Teaching the value of continuity of care: A case conference on long-term healing relationships. *Families, Systems and Health* 2012;30:302-307.
24. Palmer P. *The courage to teach*. New York, NY: Wiley and Sons, 2007.
25. Gawande A. *Complications, a surgeon's notes on an imperfect science*. New York, NY: Metropolitan Books, 2002.
26. Remen RN. *Kitchen table wisdom: Stories that heal*. New York, NY: The Berkley Publishing Group, 1996.
27. Ofri D. *What doctors feel: How emotions effect the practice of medicine*. Boston, MA: Beacon Press, 2013.

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