

# Families, Systems & Health

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## EDITORIAL

### Training Health Professionals To Collaborate

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*We discover what we believe when we have to teach it. Late spring of 1997, Susan traveled to Germany to celebrate the German publication of Medical Family Therapy and to continue a collaboration with internists in the medical schools in Aachen and Freiburg. Our Aachen colleagues asked her to speak about the training we believe to be important for Collaborative Family Healthcare. Building on the early discussions at Wingspread in 1994 about training (McDaniel & Campbell, 1996), the following editorial is based on her German talk. We publish it in this issue in conjunction with the white paper by the nursing Panel on Interdisciplinary/Transdisciplinary Education and accompanying commentaries.*

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GIVEN the changes in healthcare and the pressing need for professionals to collaborate, it is time to consider what new kinds of training we need to offer ourselves and our students in order to work more effectively. Specifically, if we want to practice Collaborative Healthcare, how do we train for it? Certainly, at this time we have no definitive answers for this question. We all need to work together to discover what is needed for innovation in clinical services. But here are some beginning thoughts, organized around the conceptual, clinical, and personal/relational awareness skills that are necessary for a competent Collaborative Family Healthcare practitioner (McDaniel & Landau-Stanton, 1991).

First, a fundamental issue: training in all these skills categories needs to occur both within one's discipline and across multiple disciplines. Training within one's own discipline is both substantive—providing core skills—and political—socializing students into the profession. For Collaborative Healthcare, interdisci-

plinary training must also occur. Having physicians, psychologists, social workers, nurses, and others take classes together is an invaluable experience. Students learn early to relate to and respect each other. We cannot train our students within the walls of our own disciplines, subtly or not so subtly infusing them with our own prejudices about other practitioners (basically, we're the good ones, and they're the bad ones), and then expect them to go out into a multidisciplinary environment and collaborate effectively.

Speaking as a psychologist, Susan's excellent graduate training included countless references to physicians as technician/practitioners who are not really scientists. In fact, when she took the job at the University of Rochester in 1980, her respected psychology colleagues in Houston said, "Why would you want to go up there and hang out with all those doctors?" It was seen as a fate worse than death!

Speaking as a physician, Tom had no exposure to mental health professionals other than psychiatrists during medical school. Mental health was psychiatry, and psychiatric patients usually had severe mental illness. Thus, most of the patients with mental health problems seen in medical school were "crazy" (psychotic) and required hospitalization and medication.

It is certainly true that professional inequities in the system fuel these prejudices, but case-oriented collaboration is not the place to deal with those problems. They require political action. Good local relationships often mean that everyone benefits from resolving such inequities. In the past, it has only been personal relationships that sometimes help us rise above professional disciplinary chauvinism. Training for collaboration allows us to do more than rely only on personal relationships.

In Rochester, we have many venues for interdisciplinary training. Some of the biopsychosocial coursework for medical and nursing students is shared. Some

medical family therapy seminars include a range of professional trainees. This makes teaching fun and discussions fascinating. Especially important in reaching our collaboration goals is the fact that we train medical family therapists clinically in primary care departments. These students see patients alongside primary care residents; both groups grow up professionally sharing care and learning how to work together. It is no wonder that our graduates seek out practice situations that allow this to continue—they think it is the only way to work. That is a far cry from our own experiences of having to break down barriers after a history of relative separation. Training together provides a foundation for working together.

With regard to the conceptual skills that are necessary for Collaborative Healthcare, multidisciplinary seminars and readings are the most effective training vehicles for learning the ideas and theories that drive this approach. The challenge is to use a format that is both engaging and collaborative so that the process of teaching and the content regarding collaboration are isomorphic.

Assuming we have a dynamic way of discussing our concepts with students, what is the content that is important for these conceptual skills? The conceptual underpinning is general systems theory, understanding a symptom in its biopsychosocial and family context (McDaniel, Campbell, & Seaburn, 1990; McDaniel, Hepworth, & Doherty, 1992). It also means using the same theory to conceptualize a treatment system—how it fits together, and the roles the patient, family, and various professionals play in an overall coordinated and complementary effort.

It is increasingly important for all students of Collaborative Healthcare to study the sociopolitical structure of the local healthcare system. What population of patients is insured for which problems and by whom? We have such a diversity of

insurers that it is vital to understand the different insurances our patients elect. But, even if we achieve universal health insurance in the US, as is true in Europe, it is important for students to understand the effects of that structure on the care provided. For example, if physicians are paid a fee for each service they provide, they will, of course, provide more services. If, however, they are paid a lump sum for all the health problems of a large group of people, they will seek to provide effective care in more time-efficient and less costly ways. One thing we've learned from the painful changes in the US health system is how much financing affects the care one delivers. A useful project for any student might be to compare a local system for treating some specific problem, say coronary artery disease or depression, to that of another country's—with the assignment to examine the effects of financing on the treatment plan.

Another fundamental conceptual skill is knowledge about collaborative (versus authoritarian) principles of care for patients and for other professionals. This literature moves from modernist approaches where the doctor's stance toward the patient is a clearly hierarchical one of expert to subordinate, to a postmodernist approach where the doctor and treatment team provide medical expertise in partnership with the patient and family who are recognized as having the personal expertise and are the ultimate moral decision-makers about any treatment plan affecting them.

Trainees must be able to conceptualize a collaborative relationship before they can enact it. We define collaboration as the sharing of information, meanings, and decision-making with patients, families, and other professionals. We emphasize that the professional's role as expert is not diminished; rather, the patient and family's expertise is also recognized and a partnership is formed. The process is illustrated through case studies that show

how this kind of partnership between patients and professionals results in successful outcomes (McDaniel et al., 1990; McDaniel, Hepworth, & Doherty, 1992, 1997).

Partnership among professionals can be harder to achieve than partnership with patients and families. Conceptually, it is important to have knowledge of others' disciplinary content and culture. Medical students learn something about the content of each specialty, which is helpful. But little is done to educate them about what psychologists, or social workers, or physical therapists learn in their training; nor are these professionals taught much about physicians' training. Even across medical specialties, more needs to be done to deal with the differing perspectives of, say, surgery and medicine. Taking courses together helps this to happen informally. There is scant formal literature about others' disciplines except for journal articles that bring content from one discipline to another. That is valuable, but does not help with the culture clashes between, say, Surgery and Family Medicine, or Psychiatry and Pediatrics, not to mention nursing and medicine, or psychology and physical therapy. Humor can help to offset the tension that can arise from professional competition and role differentiation.

Critical to Collaborative Healthcare is a sense of one's own limits. When do we need to collaborate with another professional to provide the best care for a patient? In primary care, to use mental health as an example, we teach the residents primary care counseling skills for problems such as simple adjustment disorders, mild developmental crises, new-onset child behavior problems, new-onset sexual problems, and normal grieving. We suggest collaborating with a medical family therapist for problems of noncompliance, somatizing or malingering, significant anxiety or depression, family disorganization related to changes in the course of a chronic illness, and family

problems related to coping with terminal illness. Then there are problems that we teach residents are "red-flag" issues, problems that require immediate collaboration and referral to medical family therapist or other mental health specialist because they require a higher level of skill and greater amount of time than is typical for a primary care physician. They are problems such as psychosis, physical or sexual abuse, chronic or severe mental illness, previous treatment failure, and failure to improve after 3 to 4 primary care counseling sessions (McDaniel et al., 1990).

Let's assume the trainee has read the papers, listened to the lectures, and discussed the philosophy of collaboration. They have grasped the concept intellectually. Now, what are the clinical skills necessary to provide collaborative care? These include: partnership with patients, partnership with families, and partnership with other professionals. Clearly, this collaborative work must be modeled by faculty teaching the students. If we talk collaboration and practice authoritarian medicine, students will learn authoritarian medicine. We must model how to listen to a patient and negotiate a mutually agreeable treatment plan. The next time our colleagues, Howard Beckman and Richard Frankel, study the practice of internists, we hope the average length of time physicians listen to the patients' presenting complaint before interrupting them far exceeds the 16 seconds they found in their study (Beckman & Frankel, 1984). We are an impatient group! Part of teaching collaborative clinical skills is helping trainees to learn that they actually will practice more efficiently if they allow patients enough time to express their concerns and tell their illness stories. We seek collaboration that occurs in a spirit of respectful partnership, shared power, and shared inquiry. This means the interview includes language such as

"offer," "choose," and "support," rather than "allow," "permit," and "require."

Collaborating with families and providing family-oriented healthcare requires another range of skills for healthcare providers. Every patient has a family that affects that patient's healthcare. We teach primary care residents how to involve the families as resources in the diagnosis and treatment of patients, whether it involves the father in prenatal care, the parent in the care of a sick child, the spouse in the care of a chronic illness, or the adult child in the care of an older person. In Rochester, we teach residents how to do multiple-persons interviews (a skill that does not just emerge from single-patient interviewing skills). These skills allow them to conduct family meetings to gather information for diagnosis, to provide patients and families with medical information, to negotiate mutually agreeable treatment plans, and to assess families for their strengths and vulnerabilities (Glenn, 1984; McDaniel et al., 1990). While some families with complex problems receive specific attention and sometimes a referral for medical family therapy, all families can participate in routine healthcare.

Another important skill we teach all our healthcare trainees is to recognize that patients, family members, and even healthcare professionals accept a difficult diagnosis at differing points in time. It's almost as if someone in the family needs to deny the illness and advocate for life to go on, and someone else needs to help the family grapple with the hard realities. Of course, people can get polarized and move into major conflict over this. We believe the healthcare team must work to respect others' (sometime conflicting) defenses in the face of illness, while also providing patients with the information they need and want to have.

Turning now to the skills necessary for partnering with other professionals, it is important to acknowledge, first, that it is

possible to provide decent patient care when professionals just **tolerate** each other. With uncomplicated patients, this may work okay. **Cooperation** implies actually adapting to each other's care, while **collaboration** involves the shared inquiry previously described. The more complex and difficult the patient, the more important that the professionals move along the continuum from tolerating each other to cooperating to true collaboration.

Some of the same clinical skills used to partner with patients and families must be used to partner with other professionals. And yet our tendency to work in isolation and the disciplinary chauvinism that is so pervasive often gets in the way of truly collaborating to provide the most effective care for our patients. One of the main ways we attack this problem is to make trainees aware of their own biases and stereotyped perceptions about others' professions. For years in workshops, we have asked primary care physicians and mental health professionals for adjectives that best describe their stereotypes of the other profession. The results are very revealing, and shockingly consistent, having done these workshops across the US and in Mexico, Canada, England, Germany, Finland, and even eastern Hungary and Romania. Perhaps because they are rooted in the mind-body split, in all languages and across variably organized healthcare systems, the words used are the same. Mental health professionals describe the stereotypical primary care physicians as "cold, insensitive, rigid, controlling, egotistical, reductionistic, obsessive-compulsive, pressed for time, a technician, counterdependent, and somatically fixated." Primary care physicians describe the stereotypical mental health professional as "too cerebral, impractical, touchy-feely, wishy-washy, neurotic, weird, flaky, not a *real* doctor, right-brained and left-winged, and psychosocially fixated." Having these stereotypes of another pro-

fession can seriously interfere with our abilities to collaborate, and at times can make us behave in ways that bring out these very characteristics in the other professional.

We also need to educate ourselves about our nursing colleague and others, because each profession has its own practice patterns and working styles (McDaniel et al., 1990). Understanding these differences in culture can prevent blaming and power struggles. One key to successful collaboration is to view these professional differences as differences in professional cultures rather than as obnoxious personal characteristics (McDaniel, Campbell & Seaburn, 1995).

Professionals' differing goals and perspectives often get in the way of promoting a sense of community among professionals. In the best situations (now fostered in some capitated systems), mental health professionals are available to primary care providers to discuss their most difficult patients, without formal consultation or referral.

Collaboration is an essentially personal task, so personal and relational awareness is another core competency for successful collaborative relationships. Many vehicles exist in training to encourage self-reflection and understand the influences of family of origin on one's healthcare practice. For seminars, students can draw genograms of their own families and track transgenerational patterns of health and illness. What about their families led them to go into medicine? They can discuss a specific, critical health incident that occurred to them or someone in their family, and then consider how it affects their current healthcare practice. This is the health and illness version of countertransference, equally as important to those who work in healthcare as the understanding of traditional countertransference issues is to the psychotherapist.

Workshops are a usual format for students to learn how to give and receive

clear and effective feedback, another essential core competency for practicing in a team context. Teamwork, in and of itself, can also increase one's own personal awareness and satisfaction with work.

The Past-President of the Society of Teachers of Family Medicine, Macaran Baird, is fond of saying that every primary care physician should have his or her own personal therapist to discuss cases and support the work. Sometimes even more is needed, such as the support group we established in 1990 at the Hemophilia Center. Led by Dave Seaburn, the staff found relief in discussing their sense of devastation at the series of AIDS deaths that occurred in patients who had received pooled plasma concentrates in the 70s and 80s before the blood supply was screened (Seaburn, 1994). Trainees must be taught, through examples like this, to pay attention to their own emotional needs during what is often very taxing work, and to request services for themselves and their colleagues when needed. Ongoing support groups, for health and mental health professionals, can help us prevent the burn-out and secondary traumatic stress disorder than can occur in difficult patient encounters (Figley, 1995).

We also believe that psychotherapy has an important role to play in the education of healthcare professionals. In Family Medicine in Rochester, residents and fellows are able to use their Continuing Education funds to help pay for personal psychotherapy. They can also take time off from their patient care sessions for this purpose.

Through these vehicles, as well as with precepting and informal interactions, we try to model an openness about discussing personal reactions to difficult cases. Our goal is to stress the importance of taking care of one's own personal and family issues in order to be able to be an effective collaborator.

To summarize, we teach our students that, conceptually, clinically, and personally, the top three ingredients for effective

collaboration are: relationship, relationship, and relationship. The quality of the collaboration between two different health-care providers, or between the providers and the family, reflects the quality of the relationship among them. Certainly, we each can be independent and effective on our own, but as a team we are greater than the sum of our parts. (See the Appendix for a listing of the collaboration skills discussed in this editorial.)

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