FROM THE EDITOR

Self-reliance and Collaboration

John Saultz, MD

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The first family medicine residency programs started in 1969 were required to include training in the social and behavioral sciences.[1] Most accomplished this by hiring behavioral science faculty members to teach these skills.[2] From the outset, the focus of these faculty members was on pedagogy; they were there to teach residents and not to provide direct patient care. It was assumed that graduating residents would enter practices without behavioral health resources and that the graduates would need to independently care for people with common mental health and family problems and refer those with serious mental illness to specialists. This model has been changing since the adoption of the primary care medical home over a decade ago. Today, behavioral health faculty have increased in number and have become integral parts of interdisciplinary care teams in most residency practices. This has changed the roles of behavioral health faculty. It is also changing the roles of family physicians.

Featured in this issue of *Family Medicine* is an important article about the integration of behavioral health and primary care.[3] In this paper, Matt Martin, PhD, and colleagues have described how they used a Delphi process and focus groups to identify a list of essential competencies for family medicine residents to master before entering practices with integrated behavioral health teams. The methods used in this study are rigorous and the results are of broad importance to all family medicine educators. The paper concludes that 22 competencies should be mastered by physicians working in integrated teams with behavioral health professionals. These are listed in Table 1 of the paper. It is likely that this list of competencies will be welcomed by family medicine residency directors and faculty and that they will also prove useful to medical student educators. And yet, there are aspects of the paper that are troubling, and these become more apparent with each repeated reading. First, there is the matter of the question being asked. The authors' research question was focused on relational and team skills and did not address specific clinical skills in behavioral health. They acknowledge in their introduction that lists of such skills already exist, but the list of competencies resulting from their study says nothing about the ability of family physicians to independently diagnose depression or bipolar disorder. The list includes nothing about individual or group counseling skills. Instead, the competencies described focus on teaching family physicians to incorporate behavioral health professionals into the care of patients and how to communicate with those professionals in a collaborative way. Little insight is provided about when such collaboration should occur. The authors state,

> The final list of competencies describes a vital and specific role for physicians working with team members to share the majority of responsibilities like screening, care planning, and follow-up.

But the paper does not tell us what the physician's specific role should be. Perhaps this is understandable. After all, there are already well-established curricula defining behavioral health competencies in residency education.[4] Martin and colleagues imply that the

relational competencies listed in their paper should be added to these existing objectives, but they do not address how this could fit into an already full residency curriculum. They are also unclear as to which patients will benefit from an integrated model and which behavioral health needs are best served by the family physician personally.

A second concern is the use of language in the paper. The terms "medical provider" or "primary care provider" are used seven times in the paper. The term "physician" is used 11 times. But the terms "family physician" and "family medicine resident" are used only twice respectively, even though the title of the paper suggests it is about family medicine residents and the skills required of family physicians. Presumably, the focus groups were asked about competencies needed by family physicians. Do family physicians require the same or different skills than other physicians working in primary care? Do the same competencies apply if we are talking about physician assistants and nurse practitioners? Family medicine residencies are designed to train family physicians to care for children and adults, for men and for women, and to do so with a comprehensive set of clinical skills. Using nonspecific language suggests that the study is more about how behavioral health professionals want to be treated than what family medicine residents need to learn.

A third concern relates to the population whose opinions were sampled by the process. The authors state that the final list of competencies was reviewed by "twelve primary care physicians and nine behavioral health professionals," but every author on the paper is a behavioral health professional and the final focus groups were conducted at the national conference on behavioral science in family medicine. What do you suppose the response to this list would be if it were shared with a group of rural family physicians from small town America? Because the study question focused so intently on team-based skills, the issue of what specific behavioral skills are required by family physicians is unaddressed. So as useful as this paper might be to educators, it provides little guidance for family physicians working in settings where integrated behavioral health is still aspirational. In fact, if the competencies listed in this paper replaced rather than augmented independent clinical skills, it could reduce the availability of behavior health to many American communities.

Integrating behavioral health and primary care is a core element of family medicine's strategic view of the future. This is abundantly clear from papers published in this journal that arose from Family Medicine for America's Health.[5,6] Because family medicine residencies have always included behavioral science faculty members, our residencies are generally ahead of most community practices in making integrated care a reality. In fact, fully-integrated behavioral health is still an experimental model being applied mostly in large urban health systems, academic settings, and some community health centers. Most graduating residents will still enter practices without such resources. In such settings, a family physician must function independently. So the most important question remains: how can we best prepare graduating family medicine residents to care for people with behavioral health problems in a health care system undergoing rapid change? Outside of academic and integrated health system settings, there is no business model to pay for fully-integrated behavioral health. Until such business models exist, we will continue to have many community practices without such resources. So for now, graduating family physicians need far more than good communication and team skills to provide the care their patients need. We should ask ourselves whether sufficient behavioral health skills can be learned if residents send every patient with a behavioral health concern to other members on their teams because this is becoming the care model in many residencies. Surely we can teach future family physicians to be both independently competent and collaborative. Won't self-reliant competence in behavioral health make family physicians better team members?

All of this being said, we should not blame Martin and colleagues for addressing a very specific question. That is what research is supposed to do. Their paper provides an important insight into where family medicine and the American primary care system should be heading. They just make unwarranted assumptions about how far we are from this goal and about the capabilities family physicians will need in the meantime. For the larger needs of our discipline right now, they have asked the wrong people the wrong question. Family physicians need self-reliant skills to identify and care for people of all ages with behavioral and family problems. They also need to know when and how to collaborate with others in delivering

such care. Over 150 years ago, Ralph Waldo Emerson published an essay on self-reliance in which he stated:

> The civilized man has built a coach, but has lost the use of his feet. He is supported on crutches, but loses so much support of his muscles. He has got a fine Geneva watch, but has lost the skill to tell the hour by the sun.[7]

Self-reliance is not just family medicine's past; it needs to be part of our future. We need to define what specific roles the family physician should play now and in the future. Maybe these broader questions will be addressed with future research in this critical area.

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