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Family Medicine

PRESIDENT'S COLUMN

Missing Tools, Missing Out

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The 2025-2029 STFM Strategic Plan's first listed goal is: "STFM will be a leader in training, leadership development, and creation of knowledge that improves family medicine education and teaching," with a supporting objective of "strengthening competencies for behavioral medicine practice and integration." Our first goal can't be reached without success in this intrinsic behavioral health objective that differentiates our physician training from the rest of medicine, including psychiatry.

To that end, last month's STFM Conference on Practice Quality and Improvement (CPQI) in Denver successfully added a new and important facet after STFM and the Medical College of Wisconsin joined forces to incorporate crucial components of the Forum for Behavioral Science in Family Medicine into this meeting. Involving behavioral science colleagues enriched the conference's content and fostered more interprofessional interactions that are necessary for achieving true relationship-based practice transformation. We hope to see you in Pittsburgh in September 2025 for next year's CPQI.

Robust access to and integration of behavioral health services is vital and there is great work being done in this space at the teaching practice level. In family medicine, the practice is the curriculum; it is nearly impossible to train an excellent family physician without a well-functioning, behavioral health-supporting practice.

However, our primary educational challenge and responsibility is to produce behavioral health-competent family physicians who have their own unique skill set in this area. This may be getting less emphasis in recent years. Practice transformation assists in the training effort but cannot displace a focus at the individual student or resident physician level. As Frank DeGruy eloquently wrote,

> Our usual family medicine patient has a set of health concerns consisting of five or six active problems, previous experiences with these problems, preferences, opinions, convictions, habits, strengths, fears, family issues, cultural contexts, personal difficulties, and so on. Our therapeutic approach must be toward that entire complex, toward a comprehensive personal care plan, and not just the diagnoses that can be pulled from it.[1]

It is crucial we don't model hastily delegating behavioral health off our family physician plates for the sake of clinical expediency. Almost everywhere, but especially in medically underserved communities, access to behavioral health professionals is limited. Seeing a family physician also still carries less stigma for some patients than seeing a mental health professional, although this issue fortunately seems to be improving over the past several decades and particularly since the pandemic.

Behavioral health skills can be a tall order to teach and more than a little overwhelming for learners. Particularly in our current clinical teaching environments, they are difficult to acquire without using specific tools that go deeper than our electronic health records' (EHRs') typical survey-based tools such as the Patient Health Questionnaire-9 and the Generalized Anxiety Disorder-7. Somewhat perplexing to me, useful behavioral-related tools I was taught decades ago seem to be largely forgotten and have fallen into disuse, or at the very least are underutilized in current family medicine training. Perhaps this is because they are not as easily transferable to an EHR template.

There are three useful pre-EHR era tools I suggest we dust off and/or re-emphasize in our training environments to promote and reinvigorate relationship-based care in an increasingly transactional-based system. The first is the BATHE technique developed by Stuart and Lieberman, as described in their landmark book *The Fifteen Minute Hour*,[2] first published in 1986 and now in its sixth edition. Using a mnemonic for Background, Affect, Trouble, Handling, Empathy that is easy to learn provides a structure that enhances a patient-centered, relationship-based approach and identifies things

not picked up by targeted behavioral-related, EHR-embedded survey tools. It counters behavioral health-related learned helplessness and encourages learners to get into deeper discussions with their patients without adding to the length of a visit. I have seen it be particularly important to students considering a family medicine career who wonder if they can effectively address psychosocial issues in a typical family medicine practice. It can be empowering for the resident physician, student, and importantly, for the patient who is encouraged to work on agreed-upon tactics prior to the next visit. I recommend putting "BATHE Technique" in a search engine to learn more.

The second missing (or at least underutilized) tool is the Balint group,[3] first described by psychoanalyst Michael Balint in 1957 after starting groups for general practitioners in London in the 1950s. Providing a safe space to explore difficult interactions enhances reflection and understanding of doctor-patient dynamics. What are termed Balint groups in some residency programs are often actually resident support groups and do not adhere to the Balint case discussion-based structure. Adjusting the model for residents may be reasonable but the distinction should be made. The coleading of a true Balint group, often by a family physician faculty member and a behaviorist faculty member, models numerous positive actions including interdisciplinary collaboration.[4] It also pushes against the idea of behavioral topics being delegated almost exclusively to behaviorists while the family physician faculty handle the biomedical topics. A Balint group reinforces the idea that one cannot be an excellent family physician without excellent behavioral health skills.

Balint groups have also been noted to increase resilience and decrease burnout[5] by emphasizing a relationship-based rather than a transactional approach. The American Balint Society (americanbalintsociety.org) started in May 1990 and was formed by STFM members[6] at a Balint theme day at the annual STFM meeting in Seattle that year. The ABS offers online Balint group leader training, a reference library, and even online Balint groups. Balint groups help alleviate the isolation of practice and help physicians deal with the emotional burdens of patient care by creating a supportive community that can transcend the effect of a non-Balint support group. Residency programs should consider making these sessions mandatory, as residents who would benefit the most are often the most reluctant to participate to avoid the discomfort of growth in this curricular area.

The third underutilized tool for teaching relationship-based care is use of direct observation (such as video recording) of resident interactions with patients in the ambulatory clinical site. If your immediate reaction is "Yes, we do that," I would emphasize the word "underutilized." The nondirectly-observed precepting encounter is helpful for getting patients treated and billed but most feedback in the office setting is based on resident self-report, and certainly nuances of the interaction are missed. There are real impediments to more frequent direct observation and there is also a need for supporting growing independence. Achieving competency-based medical education (CBME), however, provides more impetus to strengthening our behavioral training by increasing our direct observation efforts. Eric Holmboe wrote, "Without effective and frequent direct observation, coaching, and feedback, the full potential of CBME and the Milestones cannot be achieved."[7] Jennifer Kogan and colleagues published an excellent, well-referenced practical guideline-based resource for improving a clerkship or residency program's direct observation practices.[8] The quality of feedback can be improved by consistently using a validated tool such as the Patient-Centered Observation Form.[9]

Direct observation in teaching family medicine is not a new idea. Gayle Stephens wrote over 40 years ago:

> The key to learning patient management is appropriate supervision of the learner's interactions with patients. This may be done in individual or group settings with supervisors. The details of clinical encounters are exposed and reflected upon in a constructive manner over an appropriate period of time. What do the "details" include? Anything that happens between the doctor and the patient: the words of conversation, the behavior of each party, the feelings, the style, and the unspoken assumptions. All of these need to be brought to levels of awareness in a nonthreatening way, so that meaning can be ascribed and tested in the crucible of ongoing clinical relationships.[10]

So why did I include "Missing Out" in the title of this President's Column? This may be one of the most important reasons for reinvigorating the use of these tools. These are tools of family physician empowerment and serve to increase the level of patient connection. Underutilizing them has been a missed opportunity that can translate to a 4-hour clinic more readily devolving into a series of superficial transactions. Using behavioral health skills is so much more fulfilling than quickly referring out everything connected with the patient's relationships because of discomfort, lack of confidence, or lack of self-efficacy in these areas. Residents and students who first try "BATHEing patients" are often amazed at learning new things about their patient and can more readily see them as a person in the context of a life rather than as a collection of International Classification of Disease codes in the context of a medical record.

These three tools are wholly aligned with a central truth: that all patients, regardless of their stated reason for visit, are also behavioral health patients. The tools serve to create better experiences, bringing forth the meaning and joys of a relationship-based workday. Let's make sure our learners feel this more often and don't miss out on some of the best experiences in all of medicine.

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