Training for systemic general practice: a new approach from the Tavistock Clinic

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SUMMARY

A new course at the Tavistock Clinic offers general practitioners (GPs) and primary care nurses a training based on family therapy principles but directed at developing skills and conceptualization across the whole range of general practice work. The course may point to a new way forward for postgraduate training in general practice, creating links with the social sciences and giving doctors and nurses appropriate training for the 'postmodern' world.

Keywords: family therapy; postgraduate training.

Introduction

In recent years there has been an increasing interest among GPs in ideas from the world of family therapy. Although some of this interest has focused on the practice of family therapy within surgery settings,[1-4] there has also been a growing understanding that techniques used by family therapists might be relevant for everyday clinical work in the surgery, including work with individual patients.[5-9] A number of family therapists and GPs have also come to believe that family therapy ideas might enrich doctors' abilities to conceptualize and reflect upon the work they do. They suggest that this may apply at every level from routine clinical contacts to gaining a deeper understanding of practice and primary care team dynamics, as well as the wider social and economic contexts in which doctors and patients live.[10-12] To some extent, this change of focus, from exploring ways of 'doing therapy' in general practice towards an understanding of how therapeutic ideas might influence better general practice, echoes a similar transition that took place during the early decades of the Balint movement.[13,14] However, unlike the Balint movement, family therapists, and the GPs who have come under their influence, have always placed an important emphasis on theoretical learning and specific skills training (including the use of live observation, supervision, and video review) as well as more reflective seminar work and case discussion.[15,16]

Since early 1995, the Tavistock Clinic has offered half-day release courses lasting from one term to one year and specifically aimed at introducing GPs and other members of the primary care team to concepts and techniques from systemic family therapy. The majority of the participants who have attended these courses have been experienced principals in general practice (including trainers and tutors), although we have also taught registrars and assistants, health visitors, and practice nurses. We believe that the combination of theoretical and practical teaching that we now provide offers an important way forward for general practice training, both at the vocational training level and for postgraduate teaching. Since family therapy has strong links with contemporary social sciences, we also believe that the training provides a bridge between these disciplines and general practice. In addition, we propose that the course may meet a need recently identified by some writers, i.e. to train GPs appropriately for a 'postmodern' world, where the objectivity of medicine and the authority of the doctor are increasingly challenged.[17-19]

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What ideas can family therapy offer general practice?

From its origins in the 1950s, family therapy has drawn its ideas from a wide range of thinking about interactions and networks, including cybernetics, systems theory, and communication theory.[20-22] Many influential family therapists originally came from psychoanalytic backgrounds,[23] but there is now a clear distinction between the two approaches, since family therapists usually apply an interactional model of human behaviour while psychoanalysis is generally based on theories of the unconscious mind. In addition, systemic family therapists, who often work in community mental health settings, mainly pursue a style of active questioning to explore the family's problems rather than remaining more silent like their analytic colleagues.

In the United States, family therapists have had some far-reaching effects on primary health care.[24-26] A few pioneers in continental Europe have also joined this trend.[27,28] Most of their approaches have been based on the clinical application of the 'biopsychosocial model'.[29-31] However, this model also has its critics, who argue that it may be too rigid and may therefore tempt some practitioners to lay false claims to objectivity and omniscience, as with the more traditional biomedical model.[32-36]

In recent years, the world of family therapy has been greatly influenced by so-called postmodern thought in the fields of psychology, sociology, philosophy, and linguistics.[37-39] As a result, many therapists now prefer a narrative-based or 'hermeneutic' model for working with families.[40-44] They caution therapists against imposing their own unexamined and undeclared beliefs and prejudices onto consultations. They see the therapist's role not as testing the family's experience against a pre-ordained model of normality, but as a facilitator of alternative stories that make sense from the patient's point of view. They also emphasize the function of language in the *creation* of new realities during the course of any conversation between therapist and patient.[45]

Systemic training for general practice

It was against this background that the authors conceived the idea of a systemic training designed exclusively for general practice. (We are by discipline a GP and a child psychiatrist, both trained as family therapists.) Faced with the special nature and complexity of contemporary general practice, we devised a basic one-term training for GPs and other primary health care staff. We settled on several guidelines for our course:

- The course should address the whole range of work with patients, both 'psychological' and 'medical', as well looking at interactions between professionals.
- Our teaching should be based on the fundamental systemic ideas of observation and pattern, together with contexts, processes, and beliefs.
- The course should be presented from a coherent basis of

modern narrative approaches. This should be taught didactically and also modelled by our questioning of participants and our interaction with each other.

- We should introduce participants to the art of asking questions in a way that does not presuppose that doctors have prior or superior knowledge of what is going on. We should encourage a non-interpretative stance, where it is more important to listen to language than to make assumptions about hidden or 'underlying' meanings.
- Our aim should be to map out a field of thought that we believe might support and facilitate general practice, while letting participants see our uncertainty about how these ideas might be useful.

We chose a title that we hoped would best express these ideas: *Working with families and teams: an introduction to systems-based approaches in general practice.* (We avoided the word 'systemic' because of its confusing connotations for doctors and nurses.)

The pilot course took place over ten half-days. Each afternoon was divided into a first half with a presentation or other didactic input, such as viewing a videotape, and a second half usually devoted to interactional activities such as role play or other exercises to practise skills.[46] We allotted time for discussion of the previous week's learning and the set reading, which was a mixture of family therapy writing and material from general practice. By the time the pilot course started we were fully subscribed, with 13 GP participants, two health visitors, and one practice nurse. Following the successful pilot term, we ran a subsequent course for a new intake, which we extended to a year at the request of most of the participants. Beginning with our third intake we have encouraged everyone to follow the course for a whole year, and all except one have done so. This allows us to focus on video material brought in by students, to show work with live families through a screen, and to include a wider range of reading, including literature from the social sciences concerning medicine, gender, and ethnicity.

Observations

What has struck us most is how quickly the participants have moved from simply wanting to know how to interview couples and families (which is what motivates many applicants initially) to seeing the wider implications of systemic ideas in general practice. While students usually pay most attention in the early weeks to basic systemic interviewing techniques, like taking family trees (geneograms)[47] and simple methods of asking systemic questions,[48,49] they soon recognize that core ideas such as the therapeutic use of curiosity[50] or the observer position[51] are more central to a systemic stance than any specific techniques. In addition, we have found that most course members develop a voracious appetite for theoretical material, and we have added much extra reading to the original list as a result.

One recurrent theme is how to integrate biomedical knowledge with the neutral, narrative stance that therapists advocate. How can you be a biomedical doctor with important facts to impart and yet also be an open listener to the patient's story at the same time? How can you be neutral and objective when it is your job to get people to give up smoking? While there is a recognition that therapists receive better training than doctors in how to work with patients' different subjective realities, there is also frustration that the therapy literature does not offer guidance about how to work from a sound medical knowledge base. One main objective of the course has become to explore ways in which one might offer medical facts or advice with appropriate authority for a doctor in our own culture, while still allowing patients and their families to see (and to say) whether this makes sense as an account of their own illness narrative.

Because of the liveliness of all the groups and the feedback they have given us, we have found ourselves moving progressively from a more formal mode of presentation to a more informal one. We soon learned that students preferred to see systemic ideas enacted in our own conversations as tutors, in practical exercises, and in group discussion. They wanted good therapeutic practice to be constantly modelled, not just explained. An example of this was shown in a recent session where a student's video showed a possible opportunity for him to address his patient's fear of dying. We chose to interrupt the video at that moment to lead a group discussion about the anxieties that surround such moments in consultations, and about ways in which the doctor might offer the patient an invitation to express unspoken fears without creating a sense of intrusion. Following this discussion, one of the tutors briefly interviewed the other about how he might explore this sensitive area. The way we conducted the group discussion and the interview demonstrated systemic practice in action as much as the practical suggestions that emerged.

One problem we have continually encountered is the gap that exists for our students between conceptualization and skills. It is apparent that many GPs – even in highly motivated groups such as ours – habitually use interviewing techniques that are severely constrained by ideas from the dominant professional culture. These ideas include the importance of persuasion (giving up cigarettes, losing weight, etc.), health information (long, technical explanations of medical facts), problem solving (sometimes without establishing what the problem was, if any), and paternalism (making decisions about what is important without asking for feedback). Interestingly, all groups have expressed a high degree of awareness of this behaviour in themselves, together with a frustration at how hard it is to alter one's approach in practice. On the whole, those who have completed a year rather than just a term have inevitably found such changes easier to make. Three students who have now proceeded to further part-time training in family therapy also seem to find it easier to take more critical stances towards the currently dominant GP consulting style.

Another difficulty raised by student centres around their wish to learn some new certainties about mental health and illness. Many of the participants at first offer us overtly psychological formulations about all their patients (perhaps believing that this is what is expected at the Tavistock!). They seem puzzled by our agnosticism towards such interpretations and are surprised to find that we encourage scepticism towards all fixed explanations for patient behaviour.[52]

What the students have reported

Apart from the informal feedback that takes place during courses, we have conducted regular semi-structured written evaluations, including three during the pilot term and at least one every term since then. We recognize that self-reported feedback of this kind has obvious limitations, and that a fuller evaluation may need other research techniques, such as analysis of recorded consultations before and after the course. However, written feedback has been exceptionally consistent, both among participants and over time. The most striking aspect of the responses is their emphasis on general professional revitalization, as the following comments show:

> I have regained some enthusiasm for my job. I feel validated in the difficulties I have. I understand more of the system I am part of. I have stopped being too responsible.

> I can bring about change without being bogged down.
>
> Objectivity/curiosity has liberated me from the role of problem solver: Dr Fixit.
>
> I have managed to listen to my consultations again and feel I can ask different questions.

Closely connected with these responses are ones that reflect the breadth of ways in which systemic approaches can offer help with general practice:

> My thinking has changed *radically!* Created a sense of options being available when a personal system is stuck.
>
> The fact that the 'families' approach is applicable to *everything else.*
>
> Conceptual change – moving the consultation on from information gathering to systems.
>
> I feel more equal to my male partner.
>
> I am thinking about my thinking processes.

Most reservations about the course have been connected with its limited duration and the consequent frustrations that we have already described:

> I feel frustrated at work by being aware of a skill which could energize my work, but not being sufficiently skilled (yet!).
>
> My consultations are longer, list is growing and I am exhausted...early days.

However, there have been other criticisms too. It is clear that we have not successfully integrated nurses into the course; there have been difficulties recruiting and retaining them because they have less access to funding, and those who did attend sometimes felt marginalized. There have also been criticisms about the balance of activities, especially about the limited time for case discussions and the impossibility of individual supervision.

Discussion

Certain ideas that are deeply ingrained in general practice are now under serious attack. In particular, there is wariness about the tendency of influential figures like doctors and therapists to assume the right to make unchallenged hypotheses about the patient's 'hidden agenda', to speculate about the psychosomatic nature of symptoms, or to choose professional priorities (such as measurement or prevention) over the patient's. While accepting the expert's right to give advice about matters that lie within the domain of professional knowledge, critics are also drawing attention to the abuse of power that can occur when experts operate in areas such as family, culture and gender.[53-56] Sadly, such debates are often absent from undergraduate and postgraduate medical education, where paternalistic modes of intervention may go unchallenged.

In practical terms, family therapists struggle daily with the application of such critiques to their concrete and sometimes confusing encounters with families. Like GPs, family therapists deal with patients and families who may be at the extremes of deprivation and need, and who may bring to their consultations anything from unrealistic hopes to utter defeatism. To deal with this, therapists have developed a repertoire of practical interview techniques and interventions that are still largely unknown in general practice. We believe that these techniques make sense in the general practice setting. They may free doctors and nurses from feeling burdened by a sense of sole responsibility for what happens in the consultation. They may also help patients to move on in unexpected and self-sufficient ways.

Feedback from our courses has assured us that GPs and nurses find the ideas we present from family therapy both relevant and challenging. Students are impressed by the quality and quantity of theory from family therapy that has a bearing on their work. They are excited to find that there is a substantial repertoire of clinical practice that is soundly based on that theory, and that can be readily adapted for the general practice setting. What appears to be most exciting about this encounter is the sense of wider professional growth that accompanies the intellectual and technical learning. In the years ahead, we hope to explore how to bring GPs' consulting skills closer to the level of accomplished therapists, while remaining effective in a setting that is radically different from the therapist's consulting room. We also need to remember that GPs, practice nurses, and health visitors bring a wealth of their own wisdom that may be unacknowledged both by themselves and by other professionals. They have much to contribute to systemic thinking, as well as much to learn.

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