The Use of Video-Tape Techniques in the Psychiatric Training of Family Physicians

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This paper describes the use of video-tape techniques in the training of family physicians. Some general objectives for the psychiatric curriculum for family medicine training programs are enumerated. The implementation of these goals include (1) development of a library of video recordings which contain illustrative examples of psychiatric syndromes and management problems that appear frequently in family practices; and (2) use of video-tape recordings of the trainee during routine medical encounters and during counseling sessions for later review with supervising faculty. Some specific examples are cited of what to look for in the medical encounters and of how the video tape allows faculty to be more concrete in their instruction.

Following the establishment of the American Board of Family Practice in 1969, over 300 postgraduate training programs have been developed in family medicine as of 1977. There are 119 medical schools in the United States; 78 schools have full departments of family medicine, 12 schools have divisions, 3 have sections or programs, and 6 are actively planning programs in family medicine. Considerable attention has been given to the appropriate psychiatric curriculum for these programs.[1,2,3] Several general goals have evolved. (1) The family medicine trainee should increase self-awareness, and gain an appreciation of his/her effect on patients and of personal reactions to patient demands. Furthermore, he should learn to utilize the physician himself as a therapeutic agent. (2) The family medicine trainee should become a master at patient interviewing and develop new skills in the area of counseling and short-term psychotherapy. (3) The family medicine trainee should demonstrate cognitive knowledge of the common psychiatric syndromes that are cataloged in Table 1. The organic psychosis may require emergency management. The trainee will need to demonstrate knowledge and skills in this area, which requires understanding of complex physiological disturbances. (4) The family medicine trainee should demonstrate both cognitive knowledge and management skills for the common emotional problems that are seen in family practice. Table 2 lists these common problems, which might form a "core curriculum" for instructional purposes. This listing is not meant to be all inclusive.

General agreement exists that two of the major tasks of the future family physician are to help patients cope with emotional problems and to further the educational goals listed above. Still there is considerable difficulty translating these objectives into successful methods of instruction. The principles involved in the management of emotional problems are often difficult to teach by such traditional methods as lectures and readings. Also, the supervision of the trainee's care of emotionally disturbed patients is extremely time consuming, and the clinical material available during a given rotation may be limited. The widespread availability of video recording has greatly enhanced the ability of family practice educators to implement the teaching of the psychiatric aspects of this discipline. The methods described here include:

1. Developing a library of video recordings which contain illustrative examples of the psychiatric syndromes cataloged in Table 1 and the family practice management problems listed in Table 2, and
2. Recording of trainees during routine medical encounters and during counseling sessions for later review with supervising faculty.

Development of Video-Tape Library

Academic exercises that are specifically created for the purpose of combining the behavioral and medical sciences may be video recorded. They form the heart of such a library. The family physician, a psychiatrist, and student(s) gather together for a conference designed to exemplify psychiatric problems which are common and/or particularly difficult in family practice. The family physician selects from the patient population individuals and/or families around which the conference is centered. Two general criteria for selection are: (1) the family physician believes that study of an individual's or a family's problems contributes meaningfully to the teaching program, and (2) treatment of the patient(s) would be enhanced by psychiatric consultation.

The family physician explains to the patient(s) in advance that a psychiatrist will be interviewing the patient in the presence of other student(s) and that the entire proceedings will be recorded on video tape. Informed consent forms are signed by the patient(s) and are witnessed. There should be an explanation of the future use of these tapes, and the patient should be given a genuine option to refuse.

The video-tape recording begins prior to interviewing the patient(s), as the family physician presents to the

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student(s) and psychiatrist a relevant history and description of his involvement with the management of the patient. This is followed by questions and discussion among all participants. The psychiatrist then makes some statements about his preliminary impression of the situation, theoretical or therapeutic principles which might be involved, thoughts about how the interview might further clarify the problem, or other ideas which he believes might be useful to the student(s), the family physician, and the future video-tape audience.

The patient(s) is then invited to join them and is introduced, usually for the first time, to the consultant and to the student(s). The patient is reminded of the video tape and attention is called to the camera, which is in plain view. The video-tape equipment is operated and monitored by a technician in another room, an arrangement which has been explained to the patient in advance. This technical assistance improves the quality of the recordings with respect to lighting, contrast, sound, and continuity. The 45-minute interview is conducted mainly by the psychiatrist, with participation by others as the situation permits, in a relatively informal atmosphere.

Following the interview, the student(s), family physician, and psychiatrist discuss the patient's situation further. The psychiatrist attempts to draw inferences from the interview, make therapeutic recommendations, comment on the preliminary discussion, and explain how features of the patient's condition can be generalized to compare with other patients' situations.

The video-tape recording enables the participants to review, in detail, the conference in which they participated. Anyone can use it to re-examine details of technique or history, or to refresh one's memory of significant parts of the conference. Each participant has access to the tapes at his convenience and may replay them to review the conference in which he took part. What is more important is that one can gradually develop a library of such tapes, permitting trainees to view conferences on problems which have not emerged in their own clinical experience. By drawing from this library, the family practice educator is able to cover a wide range of subjects with each trainee. Each time a student views a past tape, the family physician is able to discuss with him any new issues that were not covered in the original conference. In the authors' experience, student interest and empathy with the patient on the tape appears to equal that of the student(s) who took part in the original recording session.

Recording of Trainee-Patient Encounter

In the current United States medical educational system, there are few if any opportunities for a student or resident physician to observe an experienced clinician obtain a history and perform a physical examination. Furthermore, few instructors take the time to watch a trainee while he performs a patient evaluation. Most instruction centers around what was done or should be done, with little direct observation. The technique of video recording patient-physician encounters offers an opportunity to correct this situation. Many family practice residency programs have begun recording these encounters on video tape. The subsequent review of these by the trainee and faculty becomes a potentially powerful learning experience. The objectivity of this technique provides the trainee with considerable insight. Often the resident himself is most critical of his behavior. Below are examples of what one looks for during a review of a recorded routine physical examination.

In the opening moments of the encounter, particularly with a new patient, one is looking for a warm natural introduction. The trainee is encouraged to show a respectful concern about the patient's complaints no matter how trivial they may appear. Although the interview should begin with open-ended questions, the resident is encouraged to probe gently for underlying fears that may accompany the complaint. It is stressed that if the physician can help the patient to be explicit about concerns, the physician can be more effective in utilizing the physical examination, laboratory evaluation, and finally, the summarizing conclusion of the encounter to alleviate these fears.

The resident is asked to examine the quality of the communication be-

Table 1
Common Psychiatric Syndromes

A. Organic psychoses
   1. Organic brain syndrome
   2. Alcoholic psychosis
      a. Delirium tremens
      b. Korsakoff psychosis
   3. Psychosis with acute poison and intoxication

B. Nonorganic psychoses
   1. The schizophrenias
   2. Manic-depressive illnesses
   3. Involutional melancholia
   4. Psychotic depressive reactions

C. Neuroses
   1. Anxiety neurosis
   2. Hysterical neurosis
   3. Phobic neurosis
   4. Obsessive-compulsive neurosis
   5. Hypochondriacal neurosis
   6. Depressive neurosis

D. Personality disorders
   1. Hysterical personality
   2. Antisocial personality
   3. Passive-aggressive personality
   4. Inadequate personality

tween himself and his patient. Does he use medical jargon or a language the patient fully understands? Does the physician make every effort to release tension? Does the patient feel comfortable? Is the physician sensitive to the patient's emotional response to the interview and physical examination? Is the physician warm and gentle, nonjudgmental, and accepting, or is he distant, harsh, judgmental, and patronizing? Is the physician efficient without appearing hurried? Does the patient have the opportunity to express himself fully? Does the physician pick up and pursue adequately symptoms or feelings casually mentioned by the patient? Does the physician give false reassurances? Is the physician abstract and nonspecific in his explanations? Is the closure of the encounter timed appropriately? In the concluding moments of the encounter, has the physician made an effort to deal with each problem that was identified by the patient or physician? Were the plans for follow-up or the regimen for care thoroughly explained to the patient by the physician? Are there any hints on the recording that would suggest the patient's emotional response to this encounter?

The video-recorded interview is most meaningful when the patient himself joins the resident and faculty member during the review session. This arrangement has been described in detail by Kegan.[4] It is an educational experience that provides for the resident, insight into his effect on patients, his response to patients, and his ability to use himself as a therapeutic agent.

Review of video-taped interviews is a very effective means for sharpening the psychotherapeutic skills of family practice residents. When a trainee becomes involved in short-term psychotherapy, usually centered around problems commonly seen in family practice (listed in Table 2), he is encouraged to video tape each or selected sessions. The review with a supervising faculty member that follows these sessions can be most helpful. The following are two specific examples.

Every physician who finds himself dealing with death, and in particular the family physician to whom the bereaved frequently turns for help, will be considerably more effective in alleviating his patient's pain and suffering if the physician has a working knowledge of certain principles for the management of grief that have developed since Lindemann's classic article in 1944.[5] It is general knowledge that the patient should be encouraged to "work through the grief."

The review of the video tape allows a teacher to be more concrete in instruction. A review of a tape session may show that the patient is talking in general terms by saying "Oh, Doctor, I am so unhappy!" or "Doctor, life simply is not the same." This protects the patient from experiencing the pain that would result from a detailed description of a particular event or situation involving the lost loved one. The supervising physician might suggest to the resident that he ask the bereaved to describe a particular time or event in some detail. The patient might be encouraged to describe an evening together – Where did you go? What did you wear? What did your lost loved one wear? What did you have for dinner? etc. The bereaved should be encouraged to talk about his relationship with the deceased until words flow without inhibition and carry with them the full expression of emotion. This mental effort required to face the pain of the loss is what is called the work of grieving. The resident can be guided by these suggestions during the next session with the patient. The resident and his supervisor can evaluate the effect of his attempt to get the patient to work through his grief by reviewing the video recording of that second session.

A second example is an encounter between a male resident and a female with a hysterical personality disorder. The management of such a patient requires considerable skill even when one does not attempt formal psychotherapy. In order to help the patient shift emphasis from control of others to control of self, the resident himself must learn to be a model of self-control. This means that the resident must not allow himself to be manipulated emotionally at one extreme; nor at the opposite extreme should he totally reject the patient because of the discomforts that result from her seductive behavior. Review of serial tapes can demonstrate that as closeness develops in the physician-patient relationship, the patient may feel uncomfortable and try to provoke the doctor into rejecting her. Provocations may well produce anger in the resi-

Table 2
Common Emotional Problems

A. Psychophysiological disorders
   1. Musculoskeletal (low back pain, tension headache)
   2. Respiratory (asthma)
   3. Cardiovascular (cardiac neurosis)
   4. Gastrointestinal (peptic ulcer disease, spastic colon)

B. Behavioral disorders of childhood and adolescence
   1. Hyperkinetic reaction of childhood
   2. Learning difficulties
   3. Adjustment reaction of adolescence

C. Depression

D. Anxiety states

E. Sexual malfunction

F. Disturbed family relationship and family counseling

G. Alcoholism and drug abuse

H. Emotional problems accompanying acute and chronic illness or death

I. Geriatric problems and the emotional needs of the elderly

dent. This can be captured on the video tape. The resident physician must understand the origins of his anger, realize that the patient is trying to get him to reject her, and remain steadfast in his willingness to maintain a mature physician-patient relationship.

Armed with the insight that comes from viewing the video tape, the resident may be successful in his effort to demonstrate for the first time to the patient that she can participate in a nonthreatening heterosexual relationship. When the resident recognizes that the patient is trying to arouse emotion in him, he can be encouraged to invite the patient to examine the interaction. The supervising faculty can suggest that at the next session he might initiate this process by saying to the patient, "It might be well to look at what is happening here," or "Let's try to understand what's going on," or, "Perhaps we can find out what this might lead to." The main idea is to present an attitude of observation in which both patient and clinician cooperate. This sort of cooperative effort is known as the "therapeutic alliance." As the resident attempts to develop such a therapeutic alliance during the next few encounters a review of the video tapes can access the effectiveness of this effort.

Discussion

It is extremely rare for a patient to refuse the request for video taping. It is always emphasized that this academic exercise will contribute to the development of young physicians. When approached in these terms, most patients are willing to make a personal contribution to the training program. Although the residents who are being video taped demonstrate some initial anxiety, this decreases, without exception, after one or two experiences. The family practice residents readily appreciate how powerful a learning experience the video tapes provide.

Medical students, more than residents, use the one to two-hour-long taped conferences from the library. Frequently these tapes represent the first exposure for the student to this content material. Also, medical students are more accustomed to playing a passive role in the learning process.

Resident physicians, on the other hand, have heavy patient service commitments and become impatient with prolonged conferences. This attitude has been met by presenting to the residents an edited and shortened version of the patient interview. An instructor then facilitates a group discussion centered around this interview. This provides active participation for the residents. The major value of the video-tape technique remains. Over a period of years, one can collect illustrative case interviews that are shown to each new class of residents, and each group is assured exposure to the designed curriculum.

The active collaboration between family physician and psychiatrist has been rewarding. The psychiatrist has come to realize that the family physician deals with emotional problems earlier and on a different level than the consulting psychotherapist. The traditional modes of psychotherapy can be altered to become more appropriate for the family physician. Through this collaboration, the family physician has accumulated a body of knowledge and skills that has supplemented his natural instinct to help the patient at a time of emotional crisis. To compassion has been added some additional competence. This contributes to the effort to combine medical and behavioral sciences. During the review of routine medical encounters, the consulting psychiatrist often joins the family physician and together they supervise the family practice resident. Again, this collaborative effort brings together the expertise of the behaviorist and the credibility of the experienced family physician. This collaboration and use of video-tape techniques has proven to be a most effective teaching method.

Conclusion

The authors now have five years of experience using video-tape techniques in the training of medical students and resident physicians in the psychiatric aspects of family medicine. This experience includes a student preceptorship in a private practice[6] and a university-based, family practice residency program. Several conclusions can be drawn from this experience. (1) The uses of video tape as described above have proven to be a most effective means of accomplishing the stated goals. (2) The ability to capture on tape graphic examples of psychiatric disorders makes the learning process far more efficient than simply relying on live clinical examples that happen to be available during any given rotation. (3) The objectivity and faculty feedback during reviews of trainee-patient encounters are powerful means for the resident to gain increased self-awareness.

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