Teaching Behavioral Medicine by Consultation in the Family Practice Center

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The broad goal of the behavioral medicine rotation described here is to help residents become more effective in recognizing, evaluating, and dealing with psychological problems and issues. The preceptor, a clinical psychologist, works with one resident at a time, sees all or most of the resident's patients with the resident, and consults with him or her regarding patient care and related issues. The preceptor is guided by three considerations: (1) the rotation goals and objectives, (2) the resident's expressed learning goals, and (3) the patient's problems and needs. At the beginning of the rotation, the preceptor interviews the resident regarding background and interests in medicine, family practice, and behavioral medicine and then asks the resident to complete a self-evaluation form on interest and skills in behavioral medicine. At the end of the rotation the resident again completes the self-evaluation form. Changes in self-ratings during the rotation indicate that most residents report increased confidence and ability to deal with patients' psychological problems.

Clinical psychologists and others who teach behavioral medicine with family practice residents are trying to answer the question, What are the most credible, most effective ways of teaching behavioral medicine? Hornsby and Kerr's[1] survey regarding how behavioral sciences are being taught in family practice residencies yielded some answers to that question. Most programs reported using seminars, lectures and conferences, consultation, videotape review, and co-counseling as principal teaching modalities. Some used role playing, simulated patients, and trigger films to stimulate discussion. Specific programs for teaching interviewing skills,[2] for dealing with alcoholic patients,[3] and for caring for the family as a unit[4] have also been described.

For most of these teaching methods, though, the teaching-learning encounter takes place apart from the scene of the clinical encounter. Whatever other methods of teaching may be used, there is no substitute for working directly with residents as they are providing care to their patients.

Zabarenko and co-workers[5] have provided significant anecdotal support for this contention. For one year they had a psychiatrist accompany a family physician for one hour each week as the physician saw patients for routine office care. The psychiatrist attempted to help the family physician broaden his diagnostic understanding of patients by paying attention to possible psychological bases for the patient's visit. In the context of the physician's office, the psychiatrist-teacher was able to emphasize and support the family physi-

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cian's existing skills and to add to his abilities to deal with the psychological aspects of patient care.

This article reports further study along the lines of the pioneering efforts of Zabarenko et al. A consultative model is described for individualized teaching of behavioral medicine to family practice residents, including the goals and general objectives of the rotation and the results of a systematic evaluation.

Behavioral Medicine Rotation

The behavioral medicine mini-rotation described here takes place during the second year of training in two separate residency programs. At the University of Minnesota Department of Family Practice and Community Health in Minneapolis, where this approach originated, the preceptor spends one half-day per week with the resident for eight weeks. At Broadlawns Family Health Center, Des Moines, the preceptor spends five half-days per week with the resident for four weeks. In both programs the preceptor is a clinical psychologist.

The teaching-learning content of this behavioral medicine rotation centers around problems and issues presented by the resident's clinic patients. The model for teaching this rotation, however, goes beyond the traditional resident-preceptor relationship (in which the preceptor responds when asked for assistance) to have the preceptor provide individualized consultation to residents on behavioral medicine and psychosocial aspects of all patients seen. The preceptor's teaching strategy is to see all or most of the resident's patients with the resident and subsequently to discuss the patient and related issues with the resident. The preceptor acts primarily as an observer, although an individualized way of working with each resident will evolve over the rotation period.

The broad goal of the behavioral medicine rotation is to help residents become more effective in recognizing, evaluating, and dealing with the psychological problems and issues that patients present. The goals specified for the rotation are deliberately broad and few in number in order not to overwhelm the resident. They might best be described as areas to be addressed, especially to ensure that nothing is overlooked. The following areas for the resident are included: (1) level of interest in behavioral medicine, (2) level of confidence in dealing with patients' psychological problems, (3) physician-patient relationship skills, (4) ability to systematically obtain psychological information, (5) ability to interpret psychological information (diagnosis), (6) ability to use mental health consultants, (7) ability to make appropriate psychological treatment decisions, (8) ability to be psychologically therapeutic with patients, (9) awareness of how patients react to them, and (10) awareness of own feelings, values, and needs. It can be seen from this list that the preceptor is interested in increasing the resident's willingness and confidence to deal with these issues as well as with his or her ability to do so.

Initial Interview and Resident Self-Evaluation

At the beginning of the rotation, the preceptor interviews the resident, then asks the resident to complete a self-evaluation form. The interview is structured to provide the preceptor with information about the resident's educational background and interests in medicine, family practice, and behavioral medicine. The resident is asked expressly about learning and experiences regarding psychology, psychiatry, chemical dependency, and related areas. A specific attempt is made to identify learning experiences the resident has particularly valued, for example, a rotation with a community psychiatrist during medical school.

The self-evaluation form asks residents to rate, using a 9-point scale, their level of interest, confidence, or ability in the areas listed above as general rotation goals. These same areas are also discussed in the interview. Last, the resident is asked what he or she would like to learn from this rotation. The following is a sample of residents' responses taken from the self-evaluation form: "Increase my level of suspicion in recognizing that a patient has psychological problems, and find better ways of dealing with these problems." "Clarify my role as family physician in relation to doing counseling. Learn how to make better transitions into the psychological area with patients who do not present with psychological problems." "Introduction to short-term counseling. Your percep-

tion of what I am missing with patients. How they react to me. Mistakes I make."

Teaching by Consultation

The consultation is guided by three considerations: (1) the preceptor's view of what residents need to know and do, (2) the resident's expressed learning goals, and (3) the patient's problems and needs. Initially the preceptor observes the resident by attending, but not participating in, all patient visits. Subsequently, the preceptor may either participate in a secondary role or carry the responsibility for conducting the interview, the choice depending on the patient's problems and the resident's need for assistance in handling the situation. The preceptor's role may be decided upon in advance between resident and preceptor or may occur as an accommodation to an emerging situation. In any case, the resident introduces the preceptor to patients with a statement to this effect: "Dr. _____ is seeing all of my patients with me today as part of my training. Is it all right with you if he joins us?" Rarely do patients object. On the contrary, many express satisfaction with having two professionals attend them.

The preceptor observes the resident taking care of patients in order to determine how the resident works and thinks. This information, plus the information gained from the prerotation self-evaluation and interview, suggests to the preceptor how best to work with each individual resident. At first the preceptor focuses on the patient, diagnosis, and therapy. Later the physician-patient relationship and the resident's practice patterns and needs are addressed. Throughout the rotation it is important that the preceptor be sensitive to each resident's level of expertise, anxiety, and openness to all these issues.

When the preceptor interacts with a patient or conducts the interview, the resident has an opportunity to learn how an experienced preceptor works and thinks. In the process the preceptor can demonstrate concretely how to create a working relationship and how to obtain psychological information without alienating the patient. For example, tactful inquiry into sensitive areas of the patient's life (eg, sexual functioning, alcohol and drug use, and adequacy of child care) may be demonstrated. The preceptor may also show the resident more effective ways of moving from evaluation of symptoms to inquiry about the patient's personal situation and adjustment.

During the University of Minnesota Family Practice Center rotation, the resident is expected to do one psychosocial workup of a patient using the Psychological Systems Review (PSR) format.[6] In addition to considering the patient's presenting complaints, the PSR format inquires about the patient's current emotional status, reasons for coming, personal situation (including work, family, friendships, etc), and personality. A family diagram, a brief description of health status and adjustment of individual family members, and description of family relationships are also included. The resident is encouraged to use other psychological assessment techniques such as the Personal Inventory,[7] the Minnesota Multiphasic Personality Inventory (MMPI), and the Family APGAR.[8]

In the Broadlawns Family Health Center rotation, the resident's clinical patients are scheduled for 30-minute visits with the resident and preceptor. No attempt is made to screen patients for particular types of problems; rather, the emphasis is on illuminating the psychological and social issues each patient presents when coming in for routine care. Nurses ask patients to complete the Personal Inventory and Family APGAR while waiting in the examination room so that this information can serve as a basis for discussion. The resident also is asked to construct a three-generation family diagram for the patient.

The Broadlawns rotation, which provides the resident and preceptor more time to be together (five half-days per week for four weeks) than does the Minnesota format, consequently is able to use a greater variety of teaching techniques. The resident is asked to read a number of articles pertaining to ethical aspects of medical practice, office counseling, developmental deviations in children, family functioning, and physician mental health. These materials are discussed, and an effort is made to integrate didactic information with what the resident and preceptor encounter clinically. Occasionally videotape review is used, particularly when the resident desires feedback on independent counseling efforts.

In both programs at the end of the rotation, the resident completes the self-evaluation form a second time. In addition, at Broadlawns the preceptor

furnishes a written report on the resident's progress to the program director midway through the rotation and at the end of the month. Observations and impressions contained in the report are discussed in a meeting with the program director, resident, and behavioral medicine faculty. Discussion focuses on which aspects of the rotation have been most useful and least useful and on the resident's additional learning goals.

For the behavioral medicine preceptor, this style of teaching often increases credibility among residents by demonstrating the psychologist's willingness to work on the resident's own "turf." Residents also seem to derive a good deal of support and encouragement from the experience.

While the self-evaluation method is subject to criticism regarding its validity, this approach identified starting points for consultative teaching by eliciting the resident's own agenda. Objective evaluation of clinical skills and clinical judgment in the area of behavioral medicine is a complex and subtle task. Ideally, self-evaluation and objective evaluation would be combined. The preceptors did evaluate some of the areas (at least those that were most observable) that were included in the self-evaluation such as utilizing a systematic logical approach to obtaining psychological information, interpreting psychological information, treatment planning, and treatment.

Results

Data from the resident self-evaluation forms are available for 20 second-year residents, 10 from each program. Table 1 presents median prerotation and postrotation ratings based upon a 9-point scale (1 = lowest rating, 9 = highest). This table also shows the percentage of residents having a higher self-rating at the end of the rotation, for each program and for both programs combined.

Prerotation ratings for both programs indicate that the residents' reported level of interest in dealing with the psychological aspects of patient care (median, 7) exceeded their level of confidence (5) and abilities (3 to 5) to deal with these issues. Residents rated more highly their skills in developing good physician-patient relationships, awareness of patients' feelings, and awareness of their own feelings than they rated their abilities to obtain and interpret psychological information, to utilize consultation, to make psychological treatment decisions, and to be psychologically therapeutic with their patients. In sum, residents initially reported themselves as interested in psychological medicine but less confident and able than they would like to be in practicing it.

Self-ratings at the end of the rotation indicate that most of the residents reported increased confidence and abilities to deal with patients' psychological problems. Statistical significance of each of these changes, according to a paired t test, is presented for the combined data for both groups in the last column of Table 1. Significant changes are found in all areas. Changes occur most consistently in the areas of (1) ability to systematically obtain psychological information, (2) ability to be psychologically therapeutic, (3) ability to understand and interpret psychological information, and (4) ability to make appropriate treatment decisions based upon patients' psychological needs.

Comment

Teaching behavioral medicine by working closely with the resident during actual patient visits provides unique opportunities for teaching, especially when the preceptor knows the resident. By determining each resident's background and agenda for the rotation, it is possible to key the teaching and learning to the resident's perceived needs as well as to the preceptor's goals for the rotation. The psychologist preceptor's visible contributions to the resident's ability to provide patient care seem to override any concerns residents might have about seeing patients with someone who is not a physician. Beyond the value of receiving feedback about their interaction with patients, residents comment on the value of observing the preceptor working with their patients, both as diagnostician and as therapist. During the rotation, residents and preceptors repeatedly note the power of teaching by modeling.

The structured, individualized teaching approach described here relates directly to how the residents practice. This teaching approach could be used by the family physician preceptors as well. Though doing so could appear to add to the time and cost of teaching, in fact, this approach may

Table 1. Family Practice Residents' Prerotation and Postrotation Self-Ratings of Behavioral Medicine Skills

Items	Minnesota Median* Pre	Minnesota Median* Post	Minnesota Residents with higher postratings (%)	Broadlawns Median* Pre	Broadlawns Median* Post	Broadlawns Residents with higher postratings (%)	Combined Residents with higher postratings (%)	Significance
Interest in dealing with psychological aspects of patient care	7	8	30	7	7	60	45	.01
Confidence in dealing with patients' psychological problems	5	6	80	5	7	90	85	.001
Skill in developing physician-patient relationships	6	7	60	7	7	50	55	.01
Ability to systematically obtain psychological information from patients	5	7	80	3	7	100	90	.001
Ability to understand and interpret psychological information about patients	5	7	60	4	6	100	80	.001
Ability to use consultation from mental health professionals	5	6	40	5	7	80	60	.001
Ability to make appropriate treatment decisions based upon patients' psychological needs	4	6	80	4	7	80	80	.001
Ability to be psychologically therapeutic with patients	4	6	90	4	7	80	85	.001
Awareness of how patients react to me	6	7	60	6	7	60	60	.01
Awarness of my feelings, values, and needs	6	7	50	7	8	60	55	.01

*n = 10 second-year residents at each program

represent a more economical, effective use of preceptors. When used by family physicians, this approach could help them demonstrate what family practice is *in practice*.

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