MEDICAL-PSYCHIATRIC COTEACHING

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BACKGROUND

Psychiatrists have become increasingly involved in teaching medical students and non-psychiatric physicians about the psychological aspects of patient care. Teaching occurs in a variety of settings: case consultations, clinical conferences, seminars, and lectures. Because the purpose of this teaching intimately relates to clinical activity, educational endeavors ideally should be integrated into the clinical program.

In this spirit, the students and faculty at the U.C.S.F. School of Medicine have developed a new teaching program for medical students called the Psychiatric Aspects of Medical Practice (P.A.M.P.).¹ Third year students are taught psychosocial and psychiatric medicine at a weekly patient care seminar that is held during all nonpsychiatric clinical clerkships.

There has been some opportunity in this context for conjoint teaching with the medical faculty. Often the non-psychiatric physician has inquired about opportunities for conjoint teaching. Coteaching adds the important perspective of the experienced medical clinician and seems an obvious asset without apparent drawbacks. Despite Engel's urging that psychiatrists support and educate those physicians with an "affinity for the psychosocial,"² there has been little comment on this form of mutual support and education.

METHOD

Though the psychiatrist may be effective in teaching students about the psychosocial aspects of medicine, teaching with an active medical practitioner seems to offer several clear advantages. His presence supports the

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importance of the course and its perspective. A clinician can both testify to the course's utility, based on first-hand experience, and enrich the clinical orientation.

Coteaching provides "in vivo" evidence of educational collaboration among medical professionals. Hopefully, students can see that the areas of clinical agreement are large and that differences in approach to patient care are reconcilable. Coteaching also provides a transition for non-psychiatric clinicians who wish to teach independently in the course.

At the inception of the course, we were concerned with the course's acceptance and establishment in the medical curriculum. Potentially each coteacher becomes a powerful advocate of the course in educational councils of the medical school.

Of significance to the health care system, each coteacher is reinvigorated in applying the lessons of the course in his clinical work and teaching in the system-at-large. The fruits of the course are harvested at clinical rounds when the instructor attends.

Those who coteach must be sensitive to possible difficulties in order to enhance the ultimate effectiveness of medical-psychiatric coteaching.

Though the psychiatrist welcomes the interested inquiry from his non-psychiatric colleague, there can be difficulties in accepting a colleague as a coteacher based exclusively on his interest and general teaching experience. In one instance, a staff physician had sought out the psychiatric instructor to express interest in coteaching. The physician had a wide-ranging background in teaching medical students. Since the psychiatrist was eager to coteach, knew of no other potential teachers, and was impressed with the background of the interested physician, he accepted the physician as a coteacher.

However, the new instructor's interviews with patients were doctor-centered, not patient-centered, failing to adequately allow the patient to tell his story. Other problems with the instructor's patient interviews became evident.

Teaching in this context requires more than interest and general teaching experience. The teachers demonstrate their own skills in dealing with patients. Familiarity with the potential teacher's care of patients is of considerably greater value than statements of support for the course and an impressive Curriculum Vitae.

Areas of a medical coteacher's administrative responsibility may become a focus for the group. In effect, this process diverts the group from the objectives of the course. Important issues such as the student's role within the clinical team and the organization of the clinical rotation deserve thorough consideration. But, these concerns can crowd out other equally important areas of patient care for the developing physician, areas more central to the goals of this course.

In choosing to coteach with a colleague, there is a presumption that the colleague's clinical activity and influence on the health care system approximate the ideals of the course. Students may directly question this assumption. In one instance a medical coteacher was criticized by the students for tolerance of negative patient stereotypes at *his* attending rounds. In coteaching such a course, it is important to remember that students examine the goals and activities of the course in relation to the larger area of clinical activity. Instructors' clinical activity can and should be a demonstrative application of the course.

With the often redoubtable boundaries between psychiatry and medicine, teachers may be specialists unfamiliar with their coteacher's area of professional experience. The teaching sessions may recapitulate the worst aspects of fragmented medical care. Inevitably, some didactic interaction is based on the specialized experience of the instructors. To be avoided is the experience of instructors who share space and time but fail to conceptually and clinically relate emotional and illness factors, suggesting that these clinicians are unable or unwilling to integrate the psychosocial and biological aspects of patient care.

RESULTS

The course is an important forum for expressing student fears and doubts. The medical coteacher may appear to represent a medical world that is indifferent to the student experience. Students may prematurely charge the medical coteacher with attitudes seen as intrinsic to the medical world. Students often feel that revelation of disturbing feelings is discouraged during medical training and carries the risk of a poor evaluation by supervisors. An effort is needed to counteract these presumptions.

Very effective cooperation between instructors can lead to difficulties of another kind. Though the medical-psychiatric coteachers confirm areas of mutual interest and the ability to teach together, difficulties may arise if students have not become sufficiently involved in the process. In one session, the instructors found themselves talking with each other, enjoying the dialogue, and failing to involve the group. Following the session, the instructors recognized how oblivious they had become to the students. It is hard not to appreciate the enthusiasm and discernment of a medical colleague. The process of mutual confirmation and support between instructors can be so gratifying as to pale interest in engaging the students. All the more so if the psychiatric instructor has felt embattled and unappreciated by the students.

CONCLUSION

Writers^{3,4} have emphasized the need for more comprehensive goals for undergraduate psychiatric education, particularly that of bridging the gap between the non-psychiatric physician and the behavioral scientist. Undergraduate education ought to encompass more than the enticement of student into a career in psychiatry. Optimally, the psychiatric curriculum offers future internists and surgeons a framework for understanding and treating their patient. While there has been increasing discussion of a comprehensive biopsychosocial model,² there have been few reports considering the means and methods for teaching this model.

In medical-psychiatric coteaching, psychiatric and non-psychiatric physicians teach side-by-side. The success of such a venture rests upon a common ground of mutually-held objectives and assumptions. Despite the range of problems this can present, coteaching is likely to become increasingly important as psychiatrists seek to engage their medical colleagues in the education of students to provide comprehensive care.

REFERENCE NOTES

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