



## Making room for the invisible: Teaching theory in medical education

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## PERSONAL VIEW

# Making room for the invisible: Teaching theory in medical education

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In the primary care clinic, with the increasing demands of documentation and protocols, it seems the last thing that clinicians need is theory. As an internal medicine resident, I feel the focus on efficiency and patient volume daily. As a resident educator, I am reminded to keep my talks brief, practical, and with a few “clinical pearls”. In short, I am asked to think practically, instead of theoretically. If medicine has a theory, it is that disease is the enemy, and we are on the front lines of the battle. A more nuanced critique has been given time and again – that the practice of medicine contains deep-seated assumptions about the world, including that the Western medical model prioritizes disease over illness, rationality over subjectivity, and technological intervention over more natural methods of healing. Most physicians take for granted assumptions behind the medical model: for us, theory is something we avoided in college, in favor of “hard” science, data, and facts.

The world of medicine education might do well to take a page from psychoanalysis, and open ourselves up to thinking about the theoretical models behind the patient care. In psychoanalysis, the four dominant modes of interpretation are drive theory (looking at primal wishes and fantasies), ego psychology (à la Freud), object relations, and self-psychology. In a similar vein, I would argue there are four medical models that clinicians use on a daily basis: illness/disease, biopsychosocial, social-justice oriented, and relational. Most physicians are not, of course, analysts, and have to contend with the thorny real facts of disease. But even this statement is one with a certain assumption – that treatment of disease trumps all else! I will argue that physicians actually fluctuate on a daily basis on which medical model they use, and that certain models work better for certain types of patients. Lastly, discussing our assumptions with students can open up a new richness and complexity to patient care. The following four cases are typical cases from a routine urban primary care practice.

## Case 1: The illness/disease model

Ms. B is a 44-year-old female with uterine fibroids and chronic pelvic pain. I have seen her over the past year on multiple occasions for persistent abdominal pain. She was found to

have fibroids in her uterus, and also pelvic infections on prior visits. She emigrated from Haiti one year ago, and her pain developed after she came to the US, with no abatement. Prior to seeing her in the clinic, she had two emergency room visits for abdominal pain with negative CT scans, and noted to have “severe anxiety” about taking care of her family here. A social work consult was recommended, but never obtained. As I listened to and examined Ms. B I conceptualized her case in terms of the illness/disease. Yes, she had disease – objectively diagnosed fibroids. She also had a unique understanding of her own illness – a subjective understanding of the origin of her pain, and its meaning in her life. My plan became to confirm the extent of her objective disease, and talk at length with her about the connection of her pain to what was happening in her life.

## Case 2: The biopsychosocial model

Mr. S is a 66-year-old man with morbid obesity, diabetes, and hypertension. I have seen him over the past year for weight-loss management and control of his diabetes. He has not lost a pound since coming under my care, but dutifully comes every month to discuss his medications. His step-brother died during a gastric-bypass procedure, and despite weighing over 360 pounds, he declines bypass surgery. When talking to Mr. S, I find myself thinking deeply within the biopsychosocial model of disease. I know he has biologically significant disease. I know that his resistance to going to the gym and to getting bypass surgery has psychological underpinnings. I also know that his closeness to his wife of 40 years both helps and hinders his recovery. She is always on time with him for appointments, cheers him on, but at the same time seems to hold him back from taking responsibility for his disease.

## Case 3: The social justice model

Mr. W is a 26-year-old man recently diagnosed with hypertension of unknown origin. I met him during a hospital admission for a bowel obstruction, which he had due to “adhesions” (i.e. stickiness) in his bowel from a teenage gunshot wound. He has a strong family history of hypertension

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and has had minimal interaction with the medical establishment. He developed hypertension after a subsequent surgery for the bowel obstruction. At home, he has a full-time job at a company but feels unmotivated to change his exercise or dietary habits to lose weight. When asked whether he uses marijuana, he replies, “I heard it could help for high blood pressure – I could be your first test case, doc!” I conceptualized his case from a social-justice perspective. The root cause of his problems clearly began when he was shot at the age of 16, and the factors leading to this shooting were clearly impacting his high blood pressure now (anxiety, lack of social network, and frequent alcohol use). While his hypertension clearly had a hereditary component, acknowledging this was neither motivating nor satisfying to him. I engaged him for 30 min on his lifestyle, safety at home, experiences with racism that prevented him from joining the gym, and a longer discussion about what causes him stress.

### Case 4: The relational model

Mr. T is 55-year-old male with metastatic colon cancer as well as new kidney cancer. He has struggled over the past few months with the effects of chemotherapy, loss of appetite and been admitted to the hospital for heart failure. I saw him in the clinic as a routine evaluation and noticed immediately his mood was more dejected than usual. He has chronic depression which has been refractory to multiple increases in the dose of medications. For this particular visit, I conceptualized Mr. T's case relationally. He needed extensive motivational interviewing around eating habits to prevent another hospital admission for heart failure. He also needed a deeper investigation of his depression – why, as a talented former chef, he felt resigned to eating frozen dinner, and why he felt disempowered to call in about the side effects of his medications.

As a clinician, I swing unconsciously between these approaches, often within a single visit based on what I feel the patient needs. For Ms. B and her fibroids, it was an understanding of what “illness” meant to her. For Mr. S,

an understanding of what social and psychological factors kept him stuck. For Mr. W, an understanding of what structural factors underlay his medical problems, and an understanding of what would empower both of us to address these together. Finally, for Mr. T, it seemed he needed a strong relational approach to get better. Of course, there are major overlaps between each of these conceptual models. I could have chosen to focus on the structural aspects that led to Mr. W's morbid obesity, or to focus on his understanding of obesity, but practically felt that a relational approach would be more motivating to him specifically. As an educator, I think this approach offers fertile territory for teaching both students and residents, by asking which conceptual model they would use for a patient, and to justify their position.

I believe that opening our awareness to our theories can be useful in a number of ways. First, it allows us to use a different language to discuss what works for certain patients. Perhaps the patient is not merely “difficult” or “non-compliant” but instead, not amenable to one particular approach to interaction. Second, an increased awareness to theory can lead to a renewed creativity in practice. Perhaps there is unexplored terrain in a social justice approach to elderly patients, or to an illness/disease-based approach in patients from non-Western countries. Finally, playfulness with theory can help us realize that the narrative of disease as enemy is not just outdated, but also may not be useful to the diversity of patients we see.

### Notes on contributor

TOM PETEET, MD, is an internal medicine resident at Boston Medical Center. He studied philosophy and physics as an undergraduate, and was a middle-school teacher for three years before pursuing a career in medicine. His interests include medical ethics, palliative medicine, yoga, global health, medical education, and writing.

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