Brit. J. Psychiat. (1982), **140**, 202–203

Meeting

How I Teach

The Association of University Teachers of Psychiatry at its annual meeting on 25 September 1981 spent a day discussing teaching of liaison psychiatry, psychotherapy, interviewing skills, and biological psychiatry.

Opening the first session, Dr HEINZ WOLFF (*University College, London*) began by distinguishing liaison psychiatry from other consultative work as an integrated approach to physically ill patients which took account of biological, psychological and social aspects of illness in diagnosis and management; it was concerned with the meaning of the illness to the patient, his worries over treatment, fear of dying, change in sexual life: any illness or symptom had an impact on the patient's life and interpersonal relations, affecting other individuals also. All doctors needed appreciation of this attitude of mind to the patient and his illness, but consultants were very difficult to influence, and medical students, junior psychiatrists in training, and possibly junior residents were the people to teach. He had assigned a psychiatrist to each medical firm in his hospital and there was 1½ hours liaison teaching on the medical wards every week of medical students in groups of four to six who came for eight sessions. They chose any case, other than a patient with obvious psychiatric illness, and presented the history to the consultant, who then himself interviewed the patient, asking wider questions such as: "How has your illness affected you as a person?!" The aim was to demonstrate how to talk to ill people, how to widen the talk beyond the narrow physical, and to show that patients appreciated this—in fact 40 per cent of them asked to be seen again—so that students saw liaison psychiatry as of practical value.

Dr RACHEL ROSSER (*Charing Cross, London*) taught postgraduates, usually in a closed group of about 12 registrars and other junior staff which ran for about nine months. Each trainee was assigned to both a liaison and a consultative service, and the weekly supervision groups were used to discuss single cases. The group looked in detail at modes of referral, types of interview (whether to challenge, or to interpret, perhaps), how to involve nurses and other staff, dealing with potential conflicts of values and priorities between psychiatrists and other specialists, ethical or legal issues, management of attempted suicide, psychological factors in symptom thresholds, use of psychotropic drugs in the physically ill and elderly, and a host of similar problems. In the discussion which followed several speakers emphasized that the psychiatric teacher must be seen to be actively helping the ward staff and the patient, and that a good knowledge of medicine (or gynaecology, or whatever) was important. Residents did not like being taught in the same group as medical students, the teacher must be a senior, and each group should have the same teacher throughout because teaching was like parenting. American experience was not a good guide, because American society and medical practice were different from British.

In the second session, on psychotherapy, Dr STUART LIEBERMAN (*St George's, London*) described how he teaches junior psychiatrists in 12 different hospitals in the South West Thames Region, with only 16 sessions of psychotherapy time per week (from two specialists). Each hospital can only be visited once in 2 to 4 weeks, chiefly for 1½ hours seminar and one hour for individual supervision of a student (for a case, or advice on studies or on personal problems). Seminars examined the doctor as an interviewing tool, treatment goals, the patient as a person, the counter-transference, and used handouts, videotape experience and role-playing exercises. Multiple-choice tests were set at intervals, and audiotapes of trainees with patients examined and discussed. Their new (1982) programme consisted of three seminars and six audiotape feedback sessions, entitled 'The Grammar of Psychotherapy', and was being monitored for effectiveness. Both he and Dr R. HINSHELWOOD (*St Bernard's, London*) thought that such teaching could only work if the climate in the hospital was favourable, otherwise junior staff would not be released from their duties, or the wrong kinds of patient would be thrust on the psychotherapist.

The following discussion did not distinguish clearly between the different needs of medical students, psychiatric trainees in general, and future specialists in psychotherapy. All doctors might need some counterbalance to the scientism a medical training could

induce, blocking the awareness of feelings; but not all trainees had the makings of a psychotherapist; and not everybody needed to be taught by a psychotherapy specialist. People could be taught in groups. Perhaps concentrating in sharp detail on one particular type or facet of psychotherapy was in the long run more effective than trying to cover the whole spectrum of methods and theories diffusely. Or was the purpose to spread non-possessive warmth, accurate empathy, and genuiness everywhere from psychogeriatrics to the adolescent ward?

Dr PETER MAGUIRE (*Manchester*) showed the value of videotapes in the teaching of interviewing to medical students. The psychiatric department received 50 students every nine weeks, showed them an introductory videotape on how to interview and three further videotapes (available for general distribution) on the shy, angry, or evasive patient. Students then received printed handouts detailing the technique to be acquired and the content areas to be covered. They were put into groups of four, each of whom interviewed the same patient for 15 minutes in front of the camera (patients liked helping the teaching) and then the group met with a tutor to view the interviews and discuss them. Co-operative patients recovering from affective disorders, neurosis or alcoholism were chosen. Tests had shown that students improved their interviewing skill dramatically in this way, and it had also been found that they (and nurses) could learn well from audiotapes of their interviews without the need of vision. Other speakers all emphasized there was nothing like a student seeing a good experienced interviewer at work in an individual situation, not in front of a large group. But in a medical school with 275 students a year, there just were not enough teachers available to take them individually, and not all teachers had a high level of interview skill. In any case there was now considerable evidence that modelling alone was insufficient. For psychiatric trainees there was more chance of witnessing experienced seniors at work, but it had to be arranged, and interviewing ought to be a specific subject of a qualifying examination. What ought the student to be thinking while interviewing?

The difficulty in discussing the teaching of biological psychiatry was that the speakers did not seem quite clear what such a subject covered, or what therefore the purposes of teaching it might be. Dr T. SILVERSTONE (*St Bartholomew's*) saw it in terms of the basic sciences of physiology, pathology and pharmacology, understanding the relationship between biological changes within the body and psychological experience. It was to be taught chiefly by lectures, seminars, possibly demonstrations and participation in research projects. Dr L. J. WHALLEY (*M.R.C., Edinburgh*) felt that the purpose of studying these sciences in a psychiatric course was not simply for their intrinsic interest but so as to be aware of possible advances in diagnosis and treatment and to be able to examine claims critically. He believed that only scientists could present scientific work with credibility but they very often failed to make their topics relevant and understandable to the psychiatrist. The class needed to have a second teacher or tutor who sat in with them throughout the course. The tutor introduced each forty-minute science lecture and led a twenty-minute clarificatory discussion after it. In addition to informal (coffee) contacts with students, he organized seminars to discuss published papers the students had read beforehand. He often gave them three papers, a classic, a good one, and one bad one, because students sometimes learned much more from perceiving the failings of a bad paper than from other reading. The discussion which followed made it clear that biological psychiatry included physical treatment which most people believed was very badly taught, or even ignored, at present; as well as methods of investigation such as EEG and computerized tomography, which also needed critical understanding; and possibly other subjects, such as medical genetics, also. One speaker in effect summarized the day by pointing out that it had started out with the presentation of well-defined structures of work in liaison psychiatry, had moved on with more disagreement and blurring of outlines to psychotherapy, had found even less agreement about interviewing, and had finally foundered in largely traditional vaguely-outlined teaching methods in biological psychiatry; while the way to teach social psychiatry had not been considered at all. He thought this reflected conventional assumptions—that everyone picked up the essence of social psychiatry by working in day hospitals and breathing the air of therapeutic communities and expected to be exposed to the natural sciences in the course of medical training, whereas psychotherapy had only latterly gained in credibility in Britain and liaison work was a new and active growth. There was only one answer to this, and the chairman gave it: whatever might be wrong with the day's symposium it ought to have sent us all away questioning our own teaching practice and open to changes and improvement; the best teacher was undoubtedly the enthusiastic one.

(Membership of the Association of University Teachers of Psychiatry is open to all who teach in medical schools, whether medically qualified or not: subscriptions £10 per annum. Further details and applications for membership from the Honorary Secretary, Professor S. Brandon, Department of Psychiatry, University of Leicester).