THE TEACHING OF PSYCHIATRY

By

D. EWEN CAMERON, M.D.

Department of Psychiatry, McGill University, Montreal

THE preparation of the men to staff the psychiatric centres and services, the laboratories and installations which have come into existence in such numbers and within so short a period in almost every country has been a task of the first magnitude.

All major universities on the North American continent have now opened up departments of psychiatry and all others are clearly destined to follow their leadership. Clinical departments have been and are being opened up in countless associated general teaching hospitals. Clinics and laboratories and instructional centres of all kinds have been organized to provide not only the basic teaching but also the increasingly diversified instruction which is now being demanded as our field becomes the more variously structured.

Since World War I on the North American continent alone more than 10,000 psychiatrists have been trained and many times that number of men preparing themselves to enter other fields of medicine have been given a knowledge of human behaviour entirely unavailable to their predecessors. This has been one of the great academic enterprises of our times.

Sweeping though these administrative and organizational designs have been, we can see the nature of this massive movement in most living form in the new premises of psychiatric teaching.

The teaching of psychiatry has been developed under circumstances of pressure and stress which are exceptional. On the one hand we are impelled by a demand of the utmost urgency that medical men must immediately be prepared and fitted to deal with mental illness, so costly in material terms, so devastating of human nature. They are exceptional because of the now widespread professional and public recognition of the immense and pervasive penetration of mental illness throughout all our populations. On the other hand the fact that the development of psychiatry has been so long delayed is due not to simple neglect but arises from powerful, as yet ill-understood, opposition to facing this area of human life and health.

This opposition comes from sources deep within our system of social beliefs and organization. It comes from struggles with our instinctive drives, from our attempts to control them by deprecation and banishment. It comes from the singularly though narrowly successful development of our system of medicine, based upon a philosophy of science derived from the physical disciplines of biochemistry, physics and chemistry—a system which is ill-fitted to deal with those non-logical, non-rational, uniquely personal factors which we now know so greatly to affect the course of human ill health.

The outcome of this long struggle between these contending forces is being swung in favour of humanism. For within the last fifty years there has arisen into dominance in all our societies the determination that we must have and put to work a knowledge of human nature far more effective than we have yet possessed.

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This demand springs from great and compelling sources. The exceptional expansion in numbers, power and complexity of human societies everywhere, require as a simple necessity of survival that men understand themselves and each other to a degree which they have not in the past. Moreover as our societies grow in power and complexity we have a need growing in equal pace to provide men fit to operate these societies, and hence, wherever we turn, whether it is to industry, to education or to the expanding fields of communication or to medicine itself, we find this insistent demand that those who are preparing themselves to enter these great and central areas in the societies of men must be fully versed in our modern knowledge of human nature.

In this presentation I shall not deal with the technical procedures, interesting though many of them are, which have been developed to aid in the teaching of psychiatry. Nor shall I deal with the great administrative problems, such as how to ensure that the number of men trained in psychiatry may rapidly be made adequate to meet the overwhelming demands that are now swamping even the reinforced numbers of us already in the field. Rather I shall endeavour to place before you certain new conceptions concerning the teaching of psychiatry which have been taking form in the last several decades and which are now being set into action. It is perhaps of particular interest that these new conceptions finding their primary origin within the thinking of the teachers of psychiatry are now none the less spreading, as we hoped they would, to other disciplines of medicine.

Hitherto it has been customary to think of medical teaching as a pedagogic procedure which finds its methodology in a traditional system of pre-clinical and bedside teaching, seminars and clerkships, all expressed in the organizational form of a curriculum to which the various departments make their often highly separate contributions. In this discussion I am proposing that we should look at the preparation of men, both at the undergraduate and postgraduate levels, in terms particularly familiar to us, namely, as a psychosociological process bringing about changes in these men—changes in their knowledge, their skills and their attitudes, these being the changes which we consider necessary in the preparation of the medical man and later the psychiatrist.

We are presently much concerned to see to it that our teaching is no longer based upon those abstractions, diseases, but is founded upon the living realities of people who are sick. There is every sign that this self-same intense concern with individual human nature is leading us to see the student and to work with him also as a person. In a word there is a shift from the teaching of classes to the teaching of individuals.

In a former day the student was seen as a mass unit rather than as a person —much as we conceived of the economic man, the typical boy, or the average housewife. The undergraduate student, it was believed, came to his first Monday morning lecture innocent of all beliefs and information likely to affect his taking in the medical knowledge with which he was to be inculcated. Thus it was thought that by suitable exposure to lectures, by watching how his instructors worked, by reading to amplify and engrave what had been taught him, there ultimately became laid down in his mind the myriad pin-points of facts, the patterns of the required skills, and the network of theories necessary to bind the whole into the standard form of the well-trained professional man.

The process, as can be seen, owed much to the model of the machine which then dominated our thinking concerning how the human being lived and worked.

Now this has changed. It has changed in considerable measure by direct

studies of the learning process, and to this psychiatrists have made their contributions through their investigations of individual and group dynamics. We now see learning as a process which brings about change. It is a process which achieves change in the individual in the form of increased knowledge, increased capacity to recognize and understand health and illness; change in the form of the acquisition of a complex series of skills, the development of the essential scientific, professional and humanistic attitudes. These changes go forward under the incitement of varying motivations and through group and individual reactions.

The group reactions take place between the instructor and the student, the student and the patient and between the students themselves. The learning process also proceeds in terms of intrapersonal procedures. This perhaps we are in some danger of forgetting in our intense concern with group dynamics. None the less reflection and reading, conjecture and solitary consideration can and do lay the basis for some of the more solid learning which we achieve. We see, then, in the terms of our new conception, that learning is a process, and that our knowledge of this process and of what alteration it is necessary to bring about through that process represents the central core of our medical teaching in general, and in particular our teaching of psychiatry in the undergraduate and postgraduate curriculum. This is basic to our understanding of the developments which are going forward in medical education. It forces us to rearrange many of our conceptions of teaching; raising some into prominence, abolishing others and indeed bringing some altogether new dimensions of teaching into consideration.

Knowledge, as we are aware, does not expand in one direction only but spreads out, unevenly it may be, but certainly in all possible directions. Hence we have come to recognize that learning is not only a process but also that it is far from being a simple two or three factor interaction: student/instructor/material. The old saying that the best university is a log with a student sitting on one end and Dan Webster on the other is, at the most, picturesque. We are increasingly aware that a great array of factors promotes or hinders the process of learning. To investigate and understand the highly complex and powerful forces which act upon the medical student and the psychiatrist in training, to study how they promote or hinder the appearance in him of the desired changes, we may with great advantage make use of the working concept of the field of force.

Using this concept, we see the student on coming to the university as entering a field of social force, this field being comprised of the medical school, the hospitals, the clinics and community services, the places where he meets his fellow students or where he thinks and studies by himself, his own capacities and attributes and his various instructors. This is the field in which those forces act which will ultimately turn him into a doctor and later into a psychiatrist.

This concept of the learning area as a field of social force has a number of values. In the first instance it brings out clearly the fact that learning is affected by a multiplicity of factors. As we study each component of the field we see for instance that the size of a group in which the student studies is of importance, as is the psychosociological structure of a particular clinic, or ward or service in which he works. And we are realizing that even the architectural structure and seating arrangements may have an effect on learning.

The second value is that it breaks us free from the long set, firmly binding conceptions as to how teaching should be carried on, conceptions which have been taken over somewhat uncritically by the numerous newly established

departments of psychiatry. And finally it is of particular value in demonstrating the vast amount of exploration and experimentation which awaits us before we can expect to have more than a beginning knowledge of the processes whereby learning goes forward.

Let us look first at the most important component of the field, namely, the student and then at some of the relations which exist between him and other constituents.

We now know that on the very first day that he comes to medical school he already has definite attitudes and basic premises concerning human nature and that these greatly affect his capacity to learn. Moreover, the student, far from being a unit is as various in his nature as the sands of the sea. None the less we may say that it is true of the majority who come that they have a warm interest in human nature.

Here we must record a most disturbing fact, namely, that the first-year student comes with a mind more open to perceive the facts of human nature than he will have after he has completed the first year or two of his medical curriculum. For during this year or two he will have been much impressed by, and strongly indoctrinated with, the great values of the use in medicine of a scientific method which unfortunately was evolved not from the study of living organisms but from our investigations of physics and chemistry, astronomy and mathematics.

One of the major advances in our understanding of teaching in the undergraduate years has been our recognition that along with the vast gains made through the application of the scientific method to medicine there have also sprung up some serious consequences. These consequences are first the appearance in our teaching of the principle, widely used in experimentation, of the isolation of the subject under consideration from its context. Hence we have subjects pursued in fragmented isolation from the total person as has been the case in some of our teaching of pathology, of biochemistry, and of physiology, or of patients immured in hospitals and studied in isolation from their social settings. We have also noted a tendency to omit from consideration what cannot easily be made to fit into the framework of the experiment. That only too often has been the most highly adaptive and therefore the most variable aspect of the whole functioning of the individual, namely, some areas of his adaptive and instinctive behaviour.

Let us turn from the attributes of the student to the interactions which go on between him and the other components of the learning field which he has entered.

About these interactions we have some information. We can certainly say that in the last four or five decades we have come to understand that the small group constitutes a most important learning area. We can also say from our growing knowledge of group dynamics that the amount of learning which goes on in small group instruction has a positive relationship to the amount of individual participation, maximal learning tending to take place at the point of the asking of a question. Hence both in the undergraduate and in the postgraduate teaching of psychiatry great and growing weight is placed on small group instruction with maximal student participation.

As we watch the processes of learning going forward within the field of social force which we have described we can discern a second great area of relationship in which learning reaches levels of particular intensity. This area is constituted by the relationships of the patient and the student, whether undergraduate or postgraduate.

Because of our appreciation of the importance of this relationship we have already set up, both in our undergraduate and postgraduate curricula, measures to take advantage of its special value as a means of learning. In the undergraduate curriculum these measures are still new and are still in the process of being worked out. The first is quite simple. In many medical schools the student is brought in contact with the patient as early as in his first year. This has great advantages in so far that this early contact, which is continued, of course, throughout the whole four years, offsets the trend towards fragmentation of the patient and pre-occupation on the part of the student with systems—cardio-vascular, skeletal, and gastro-intestinal—rather than with the living person. It has clear disadvantages since the student at this stage in his career has passed through only the opening phases in his instruction in pre-clinical subjects and can have little more than a layman's grasp of the clinical problems set before him.

In a few centres this early contact with the patient is structured more completely and the student for instance is assigned as an observer to a woman in the sixth month of her pregnancy. He follows her not only throughout the whole course of her pregnancy but throughout his curriculum. He keeps in touch with the family and watches the growth and development of the child as well as the relationships which exist between the child and the other members of the family.

In other centres the student may be assigned to an already established family. He acts as a medical friend during the whole course of his curriculum. This arrangement, attractive though it may seem theoretically, has certain practical difficulties, among them being the obvious one that the medical school sooner or later finds itself responsible in some measure for the well-being of some 400 or more families comprising perhaps 1,500 to 2,000 people.

The clinical clerkship, of course, is a procedure long established in other disciplines of medicine. With the coming of psychiatric divisions of general hospitals the clerkship has become an increasingly common and valuable asset of the undergraduate training of the future medical man.

When we come to the postgraduate training of the psychiatrist, the learning which goes forward in the patient-therapist relationship is, of course, of outstanding significance and hardly requires to be documented in this communication. We may, however, point to an interesting phenomenon, namely, that in the last several decades it has been found increasingly valuable to introduce a third person into this relationship.

This third person is the tutor. To this senior member of the department the postgraduate student goes perhaps twice a week with the problems he has been encountering in his work with the patient. We first introduced this procedure in our centre because of the considerable anxiety which was apparently experienced by the young man in training when facing some of the psychodynamic and psychotherapeutic problems which came before him. We have subsequently found moreover that in addition to alleviating his anxiety it greatly promotes his learning. At the same time it throws light on another forward step to the understanding of the learning process. We had occasion earlier in this paper to stress the fact that learning is not a simple matter of recording but does involve considerable changes, changes which take place for the most part as a consequence of interactions going on between the student and the patient, the student and his instructors and the student and other students. This comes out particularly clearly in the tutorial situation and advantage is taken of this to show the student the importance which factors in his own

personality have for his understanding of his patient and for the management of the case. His hostilities, his blindspots, his anxieties, all can be shown in operation in this relationship and all can be dealt with through the unique position held by the tutor.

Turning again to the learning process as it goes forward in the field of social force, we can point to other areas in which the process goes on with maximal intensity. We have already referred to the learning which goes on when the student is studying by himself and reflecting and considering what he has learned. There is some reason to feel that some of the most important learning goes on in student discussions. These various situations have been mentioned primarily for the sake of completeness. One must be impressed however with the limited amount of knowledge which we have of these extremely important areas. We must be no less impressed with our willingness hitherto to continue to construct our curricula largely on the basis of traditional beliefs concerning learning.

Let us now turn from the relationships which exist between the various components in our field of social force and consider what changes we seek to bring about in our students, both undergraduate and postgraduate. For convenience rather than for exactitude we may divide these changes into changes in attitude, acquisition of skills and the accumulation of factual knowledge.

Both curricula have come under the sharpest possible scrutiny in post-war years. The First World Conference on Medical Education held in London in 1953 marked a high point in the intensity of this scrutiny. Since that time in many countries, national, regional and individual university bodies have been set up to study undergraduate medical teaching.

The content and purpose of both the undergraduate and postgraduate curricula has been intensely reviewed.

Hitherto we have tended to look upon the medical curriculum, both undergraduate and postgraduate, as something developed entirely within the field of medicine, distilled from long tradition. conservatively modified by departmental and faculty discussions. Yet in very fact the curriculum is a social structure which most assuredly does not exist in isolation from the world and times which it serves. It is true that the immense growth of medical knowledge has been a crucial factor in requiring the present scrutiny of the curricula but we should fail to grasp what is going forward if we did not realize that it is the expectations of our national communities with regard to health and in a broader sense with regard to the enjoyment of life that are exercising the most powerful effects on our preparation of the basic doctor and the specialized psychiatrist.

We have undoubtedly come to the end of a period in which men were trained, in the undergraduate curriculum and postgraduate courses, for diagnosis and treatment, for the detection of disease and its conquest. We have entered insensibly into a period where the primary concern is the individual and also the community.

It is in the attitudes of the new basic doctor and the new psychiatrist that we can most easily distinguish the impact of the expectations of our communities.

This latter consideration has now come into the foreground. Indeed it is the necessity of creating new attitudes, of forming new kinds of orientation towards health and illness more than the accumulation, great though it is, of new knowledge or skills which is bringing about the revision of our curricula.

In earlier days attitudes were something picked up more or less insensibly from the traditions of the school in which the young man studied and from the

example set by his teachers. Now we are drawing up explicit plans to foster the attitudes which our days and the practice of psychiatry require and in a broader sense are attempting to expand this to the whole field of medical education.

The first major attitude consists in a shift from concern with disease to concern with the patient, a shift from preoccupation with disease to preoccupation with health. This is beginning to show itself in psychiatric teaching in the undergraduate curriculum and in the fact that we are now to a far greater extent than before concerned, not so much with the teaching of junior psychiatry but with the teaching of the facts of human nature.

A second great attitude is one to which we have not given nearly so successful expression and that is that one must look at the whole person.

Despite panel teaching, the integration of teaching of groups of departments and the development of the psychosomatic approach we are still inclined to think in terms of functional and organic. The teaching of psychiatry in the undergraduate curriculum must clearly transcend the borders of the department. Unless some of our basic concepts are taken up by other departments and used by them we shall have failed. Thus far the number of other departments which carry out a complete examination of the patient on admission is quite small and certainly fewer still teach this to their students.

With regard to the gaining of skills and the accumulation of factual information a most interesting development is apparent. This is a growing differentiation between the kind of skills and the sort of facts which are being taught in the undergraduate and postgraduate curricula. At an earlier day the teaching in the undergraduate curriculum was a modified version of our postgraduate instruction. We taught undergraduate students junior psychiatry.

Now with our growing acquaintance with the enormous amount of psychosomatic illness, with the extent to which emotional and other factors complicate all types of illness, we are beginning to give more precision and a special identity to the instruction which we give at the undergraduate level. A course of descriptive psychiatry, of necessity, is included, since it is essential that the major types of psychiatric disturbance should be recognized by the future doctor, but in so far as we see the future doctor applying psychiatric concepts and working to an increasing degree with the human factor in illness, just as he does with bacteriological agents, we now seek to prepare him. We present to him the human factor in illness, the management of the patient, the doctor-patient relationship with all its potentialities for health and all its potentialities for damage. We seek to acquaint him with the nature and the dynamics of the interview and with the basic facts of human growth and development, with the ways in which childbirth and puberty, marriage, the menopause and bereavement are managed. We put before him our knowledge of our sexual drives, of our hostilities and our anxieties and how they may affect our health.

The means whereby we do this are also changing. One-way screen instruction, the use of the teaching movie and of the clinical clerkship are steadily growing.

At the postgraduate level the amount and the range of information and of skills which the student has to learn is increasing with great rapidity. There is no doubt that we are again approaching in the post-graduate curriculum the dilemma which we have long encountered in the undergraduate curriculum, namely, the impossibility, because of the vast speed of accession of knowledge, of ensuring that all the necessary data can be put before the student. We are falling back as we did in the undergraduate curriculum upon an attempt to define what areas are fundamentally important.

The matter of attitudes has already been dealt with in our earlier discussion on the undergraduate curriculum. These attitudes, which call for concern with the person rather than with the disease and with the whole person rather than with a fragment or system, are no less valid in postgraduate training. Only one other major attitude will be dealt with in this consideration of the postgraduate curriculum. It is born of the very difficulty and complexity of our field. The range of variables affecting any aspect of behaviour is so considerable and the data in itself so highly abstract that in psychiatry to an extent probably found nowhere else in medicine the postgraduate student is apt to feel lost, bewildered and insecure. For this reason there has been a tendency for the teacher to be over emphatic and for the founders of schools—it is one of the happier circumstances of the growth of our discipline that the founding of schools is now largely a matter of the past—to be quite iconoclastic in their exclusiveness. For the insecure student this is a refuge. Yet at the same time exclusive devotion to a viewpoint, while possibly affording some relief from anxiety and giving some direction to those students who cannot find their own way, is a most crippling and disabling procedure.

With our growing knowledge of how attitudes may be inculcated, beliefs manipulated, there is a serious obligation upon us to be constantly alive to, and to take every means of avoiding, the dangers of discipleship.

Turning now more directly to those areas of skills and knowledge which are showing the most rapid development, we must now stress something which in the last several years we have been in some danger of neglecting, namely, the great desirability of making phenomenology a basic area for learning in the postgraduate curriculum.

Dynamics has had a remarkable expansion and we owe much of the success of modern psychiatry to the growth of our understanding of human dynamics. And yet it is ultimately from phenomenology that some of the most important new lines of development take their origin. It is by returning continually to the basic facts of observation of what is happening, of how it can be modified, that we may hope that new fields may be opened up and answers may be found to problems which are very old indeed. Hence we find in many centres a growing utilization of the newer tools of recording, of movies, of magnetic tape recorders, one-way screens, the electromyograph, the electrogastrograph and the galvanic skin reflex, as a means of re-examining under the microscope of such tools long known behavioural disturbances such as psychomotor retardation, excitement and the functioning of those mechanisms which lie between stress and symptom.

Several of these tools have also permitted a most considerable expansion in our understanding of dynamics and psychotherapy. We ourselves supply all our postgraduate students with a tape recorder in much the same way as a student in pathology is provided with a microscope.

As a first step to successful work in psychodynamics or psychotherapy, whether individual or group, must come a prolonged training in problem identification. The recorder we have found to be quite invaluable as a means of detecting problems as shown in the patient's communication and of showing defects or strong points in the therapeutic participation of the student.

Every day with every mail we are reminded of psychopharmacology. This field is so earnestly debated in conferences and individual papers that it is barely necessary to do more than indicate that it seems probable that it is destined to be vastly expanded. We may however in passing point to two great steps which must be taken before it can play its proper part both in the preparation of the student and in the ultimate treatment of the patient. The first

is the setting up of adequate methods for experimental investigation of new psychopharmacological agents, and the second is in the provision of a theoretic structure which would permit the systematic development of new agents to meet specific needs. At the present time it is almost incredible by what rule-of-thumb procedures pharmacologists working in the drug houses apparently proceed to find new agents.

The area of the physical therapies in psychiatry is rapidly growing so complex in itself, requiring such knowledge of among other things electronics, as to show some signs of becoming a sub-speciality in itself.

This brings us to a serious consideration, namely, the emergence of special fields of work. We can note immediately that child psychiatry, community psychiatry, and industrial psychiatry have already been designated as separate, at least by name. Administrative psychiatry has also been designated and we know well that many men devote themselves almost exclusively to research and others to consultation work, and others to various forms of psychotherapy. We also know that any one of these fields is a lifelong study. To meet this therefore we ourselves have revised our four-year programme and now devote the first two years to a basic training course through which all of our post-graduate students must pass. In the last two years choice is offered and those individuals who are going into child psychiatry will spend those years in that subject, in community psychiatry and paediatrics. Those going into research will clearly spend an increasing amount of their time working under direction in the laboratories and those going into other sub-speciality fields already mentioned will receive their training accordingly.

In any ongoing process whether it is biochemical, psychological, or sociological, we are of necessity interested in one most important attribute, namely, the intensity with which the process is going forward. Hence we must be concerned with respect to the learning of psychiatry both in the undergraduate and postgraduate curriculum with the intensity with which changes are going forward within our field of social force. This is something which in the past we have dealt with only to a limited degree and in terms of traditional concepts of how learning can be facilitated.

Motivation has been sought through the use of examinations. But this is a crude and faulty arrangement and there lurks the ever-present danger that the student will prepare himself to pass the examination rather than to be a psychiatrist.

It is certain that the coming years must find other motivations and it is no less certain that the psychiatrists among others will be consulted as to how this is to be brought about. As we survey the situation we may say that we recognize, perhaps more clearly than some of our colleagues, that learning has an emotional component and that answers to our problem are probably to be found in studies in depth of those students who seem to be strongly motivated as contrasted to those perhaps otherwise no less intellectually gifted who have little motivation and may fail. Even now we can point to the fact that participation usually increases motivation, hence one of the values of small group discussion learning. We may also point to the fact that increased responsibility for the care of patients is a strong and important motivating factor.

We now pass to the last but assuredly no less essential aspect of the operation of our field of social force, and that is the assessment of what has been achieved. References have already been made to the use of the examination and to its limits. We are all much aware of what a weak thing it is, since a man who may do well in examinations may be the poorest of physicians. We are also

aware how little examinations can show of those qualities and attitudes which are essential in a physician. Some of these qualities are well known but there are others of them which become apparent to us when we meet and live with our fellow physicians. We see that patients get well, or don't, or die and we see that in some measure this is due to the extent to which the physician has a tireless persistence in their care, that he has resiliency to rebound from failure, that he has courage to take some step for the welfare of his patient, a step where if he fails the results may be damaging to him. For often he is faced with the choice of taking such steps or continuing in relative inaction for which he will not be blamed. Few of these imponderable but vitally important attributes can be discovered by examination. They can however be discovered by those who work and live with the student during his undergraduate and postgraduate training. Hence as we increase our emphasis upon small group discussion, as we employ tutors to a growing degree, as instructors themselves gain more knowledge of human nature and with the assessment of attitudes and emotional factors, we may anticipate that our capacity to measure what has been gained will be increased. And I have no doubt that our efforts in this regard will be supplemented by psychological tests still to be devised.

In this presentation we have sought to look at the preparation of the physician and later of the psychiatrist not as being brought about by the operation of traditional pedagogic principles but rather as a procedure whereby men enter an intricately structured field of social force and there participate in exchanges designed to prepare them for service in one of the great key areas of our societies.

It is a provocative thing that the psychiatrist, keenly interested though he is in teaching and research, when he approaches the matter of teaching neglects much of what is known of both fields. It is the rarest of centres that is at pains to instruct its potential teachers in the methods of teaching and certainly still rarer is it to find that the learning process in the undergraduate or postgraduate curriculum has been studied by research methods. This conception of learning as a process taking place in a field of social force has been put before you in the conviction that it is from psychiatry that there must come the impetus to initiate research into the processes whereby the student becomes the physician and reaches the breadth and stature of the psychiatrist.

DISCUSSION

By Dr. Noel Harris

I take it that the role of a "Discussor" is two-fold. Firstly, to criticize the paper that has been read, and secondly to promote discussion.

I find myself in difficulty over the first point, as I agree with so much of Dr. Cameron's paper, and I should at once like to pay my tribute to him, and congratulate him on it.

I cannot help thinking from what he has told us that in the North American continent there has been a quicker and greater development in teaching psychiatry than in Great Britain. Over here, in some Universities and Hospitals, there is still considerable reluctance and in some cases opposition to making use of the increasing knowledge of psychology. A great deal more could still be done in linking up psychology and psychiatry with all branches of medicine. It is still not uncommon in Great Britain to hear criticism, some of which may be justified, of the attitude of many medical men on "the other side of the

Atlantic" towards psychology, analysis and tranquillizers, but I feel some of the criticism is due to prejudice.

I think that public opinion and interest concerning mental illness is being aroused more slowly in Great Britain than in Canada and America.

I do so agree with what Dr. Cameron says about the importance of working in the closest co-operation with other members of the medical profession. I shall mostly reserve my remarks to undergraduate teaching on which I have been engaged for about 26 years. I consider that it is most important for medical students, nurses and all those training for the ancillary services to be taught how to establish the best possible personal relationship with their patients, and also the importance of the emotional factor in dealing with illness. I feel strongly that it is the physician, surgeon or gynaecologist who should teach these facts more frequently and as a routine, pari-passu with the pathology, diagnosis and treatment. I hope that the day may soon come when at my own hospital and all other teaching hospitals, the surgeon who is doing a mastectomy for instance will teach the students about the emotional factors involved in such an operation, and that the gynaecologist will do the same when performing a hysterectomy.

The need to consider the social side in health and illness has I think been well taught in Great Britain when we were well in the forefront with almoners. It is the understanding of the unconscious motivation of patients and the deeper reasons for their reaction to illness which is so often not taught at all. I also agree with Dr. Cameron on the importance of teaching more about health. We should pay more attention to prophylaxis and remember to promote health. Such a venture as suggested by Dr. E. F. Griffiths, whose books many of you must have read, namely, what he has called "An Institute of Family Relationships" would be well worth while in promoting health. Before the war, at the Middlesex Hospital, Professor Moncrieff and I had occasional evening groups which the parents and children who were attending the Infant Welfare Centre and Professor Moncrieff's out-patients could attend to discuss with us not only the physical health of their children but also their character formation.

I agree too with Dr. Cameron about the importance of establishing the best possible relationship between those teaching students and the students themselves. It may be interesting to note that recently the Dean of the Middlesex Hospital has started a scheme whereby each member of the consulting staff has a small group of students attached to him or her, so to speak, for providing those students with some social life and help and guidance if they want it.

I was interested in the idea of the early introduction of the student to the patient and would like more information as to the results.

I have been giving lectures in psychology to students doing anatomy and physiology since about 1936 and I am sure that this is important, but the lectures should be given not too near the time of the examination when naturally the students' thoughts are chiefly concerned with getting through their examinations. Then there are lectures and demonstrations on applied psychology in the clinical introductory course, and, about the third year, lectures and demonstrations on clinical psychiatry are given and all students attend the department of psychological medicine for a period of three months during which time they can see both out-patients and in-patients.

We seem to be faced with the problem that our present method of teaching for examinations is not really the best form of education, and one question I would like to ask Dr. Cameron is if he considers questions on psychology and

psychiatry should be set in the ordinary medical examinations. Time is running on, but one further question I should like to ask Dr. Cameron is about the use of a recording instrument. I have always been rather against having a recording instrument during the examination of a patient because of the possible distress to the patient and the question of professional secrecy. Has any difficulty been experienced over this?