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SYMPOSIUM ON THE TEACHING OF PSYCHIATRY

England: St George's Hospital Medical School, London

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I took up my present appointment at St. George's Hospital Medical School in 1967 and found myself with friendly colleagues and a tradition of undergraduate teaching of psychiatry extending back to the immediate post-war period. This tradition had also been expressed in the textbook *Psychological Medicine,* written and revised over successive years by Guttman, Curran and Partridge, and in more recent years by Peter Storey, currently a senior colleague here. The book is hallmarked by its clarity of expression and the richness of its clinical observation, and has for long been a favourite with both undergraduates and postgraduates.

In the great debate of the '40s and '50s on the nature of depression and personality disorder and their subclassifications, St. George's had played its part. The undergraduate school was small; students attended out-patient clinics, where they were expected to clerk and present patients, and they were also engaged in a vigorous four-week bedside clerkship in the in-patient unit at Atkinson Morley's Hospital in Wimbledon. This was then a small, 100-year old building which also housed the well-known neurology and neurosurgery units. I had previously worked in the unit as a registrar and knew that this experience was valued by the majority of the students. The subject was respected and, over the years, some of the School's most able graduates had joined the postgraduate ranks of psychiatry. One should obviously be wary of tampering with such a system.

I had come from the Middlesex Medical School where, under the influence of Sir Denis Hill and in the company of John Hinton, we had worked in a small in-patient unit within the main hospital. In addition to conventional services, we had developed an active liaison service (Crisp, 1968) and a behavioural and dynamic psychotherapy unit. On the teaching side, we had made one of the early attempts to develop a behavioural science course (Hill and Hinton, 1966), and a three-month full-time undergraduate clerkship in psychiatry (Carstairs *et al,* 1968). My clinical interests were in accord with these general hospital aspects of psychiatry, and I was now ambitious to graft these activities and approaches on to the undergraduate course at St. George's and its related pre-clinical school at King's College, London. Fifteen years later it is an appropriate time to take stock.

The Teaching Programmes

London University is a federal system of schools and institutions; it thereby has a potential for rigidity, built in more powerfully than other universities. Within the Faculty of Medicine alone, there are a dozen general medical schools producing between them about 1,200 graduates per annum. St. George's was and still is one of the smaller schools; our present intake is 100 students per annum, but our planned intake for 1985 of students registered for the London MB BS is 150, by which time we shall be one of the larger schools. Since 1976, we have been a combined pre-clinical and clinical school, i.e. we have had our own five-year course.

The University of London regulations governing the MB BS degree act as guidlines and constraints to the curricula of individual schools which are, however, encouraged to develop in their own way. The new St. George's undergraduate curriculum is, for London, regarded as *avant garde*, i.e. it is vertically, horizontally and diagonally integrated! At least, that is the idea.

The university regulations underwent a major upheaval in the mid-1970s, after the General Medical Council's 1967 Recommendations regarding medical education, which had put much more emphasis than before on the importance of the behavioural sciences and such subjects as psychiatry. Consequent on this, various pressure groups had developed within the Faculty including one involving psychiatrists, who believed that for their subject to be taken seriously by the students, it had to be taken seriously by the teachers, i.e. incorporated in a significant way into the examination system (Crisp 1973).

The new regulations required that psychiatry (and also paediatrics and social medicine) be examined within the medicine part of the exam, as distinct from surgery, obstetrics and gynaecology. Moreover, that approximately one fifth of this examination be given to each of the three new subjects. This has proved, in my view, an unjust intrusion into medicine, brought about to some extent by medicine itself, but now requiring review. Meanwhile, those schools such as St. George's, which have had their own school-based courses and examinations accepted by the University, have had the chance to reorganise such matters.

At St. George's, the Department of Psychiatry is involved in undergraduate teaching at a number of

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points within the curriculum. Thus, the first two years are taught mainly by basic medical scientists, though clinicians also contribute, and the expressed aim is the time-honoured one of making the subjects relevant to clinical practice. In the next two years, the teaching is mainly by clinicians, though some input from basic medical science is encouraged. An intercalated year is possible with psychology as one of the options. The final year is then compounded of further clinical clerkships and electives.

Basic medical science teaching

This is largely taught on a systems basis—courses being organised by committees rather than departments. The departments contributing to such teaching keep a wary eye on the situation, not least since the block financial grant to them is determined by their teaching contribution. Fortunately, psychology is not seen as exclusively basic to psychiatry, but also as relevant to other clinical disciplines. Equally, physiology and biochemistry are seen as relevant to psychiatry although, largely because everyone is so busy and topic teaching so time-consuming, such overlaps are less than anticipated. Nevertheless, I teach on the subjects of consciousness, attention and sleep within the neurosciences course, which occurs in the first year. Within this early contract, I attempt to demonstrate the links between memory, learning, the unconscious mind and sleep in a way that keeps dissonance at a minimum between social and biological systems in the student's mind. Indeed, both at this stage and afterwards, I regard this as one of our principal tasks, i.e. not to deny the conceptual difficulties and the areas of ignorance and philosophical debate, but to reinforce acquaintance with and understanding of the known points of contact and interaction.

The behavioural sciences course is 81 hours long and organised by a committee of five, comprising two psychologists, a representative of the Academic Department of Social Medicine, the Senior Lecturer in General Practice and a member of the Academic Department of Psychiatry. The Professor of Psychology is behaviourally orientated and the course has that emphasis, although it is broadly based. It includes the early teaching of interviewing skills, including some use of video recordings of students conducting interviews, allowing appropriate feedback, and occurs during the second year. Psychiatry is a welcome contributor, providing about seven hours of the teaching. Space does not permit a detailed statement of this curriculum here, but the details can be obtained on request from Professor Mathews in the Department of Psychology.

Clinical Course

Interviewing skills and the taking of a psychosocial history

These skills are taught by many people from several disciplines, at different points within the course. We are only now, under initiative from this department, attempting to integrate these activities, but meanwhile, psychiatry makes a primary contribution in this field within the students' introduction to the clinical course. To this end, they attend for two successive afternoons, which begin with a 50-minute lecture and continue on the basis of groups of three or four students together with a supervisor (senior members of the department, including senior registrars). Each group then jointly interviews a patient from the psychiatric unit (in-patient or out-patient services) or else from the general hospital liaison service of that week. The task is for them to elicit systematically a social and psychological history as well as a physical one. This 90-minute activity is followed by tea and discussion. Within this teaching, the importance of the doctor/patient relationship and of transference and countertransference for information gathering are emphasised at an elementary level.

Liaison teaching

After a first six months of junior medical and surgical clerkships, the students embark on a year-long cycle of clerkships in obstetrics and gynaecology, paediatrics, psychiatry and neurology. Thereafter, they return to six months of senior medical and surgical clerkships.

The psychiatric department has an established clinical liaison service to medicine, surgery and all other clinical departments and it is within this that further teaching in psychiatry can occur. Once again, the problem of limited staffing often requires that this service is no more than adequately maintained. However, some of the psychiatry firms are active in such teaching through their particular liaison links, and this may be delivered by consultants, senior registrars or the most senior of the registrars. This will either require the teacher in question to attend the medical or other ward round or arrange a separate regular time for seminar teaching. In my view, this teaching has special potential as a means of providing the students with a perspective of psychiatry as a subject of important relevance to medicine at large.

Adult psychiatry clerkship

For many years, this was for three months but, with the introduction of fixed holidays and exam revision times for students it has been reduced, together with paediatrics, obstetrics and gynaecology, to an 11-week clerkship, representing a quarter of the working year.

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The specific goals and objectives of this period of teaching are that the graduate should:

be able to take a psychiatric history and make a mental-state examination;

be aware of the diversity of theoretical formulations (models) of psychiatric illness;

understand how disturbances of bodily function may proceed from psychological causes;

be familiar with those conditions listed in the Core Nosography;*

be aware of the importance of and occasional difficulties of doctor/patient relationships, e.g. his own emotional reaction to patients, and how this may limit or otherwise affect management;

be familiar with the pharmacology and the therapeutic use of psychotropic drugs;

be cognisant of the principles of interpersonal and behavioural psychotherapy, and be able to carry out simple examples under supervision;

be aware of the organisation of psychiatry within the NHS, and of the role of the welfare and social services;

be aware of the legal aspects of psychiatric disorder, particularly with regard to the handling of emergencies.

*Core Nosography:
Affective illnesses
Schizophrenic illnesses
Personality disorders, including the special relevance of psychopathic personality disorder in forensic medicine, and alcohol and drug abuse
Neurotic disorders, including anxiety and phobic anxiety states, obsessive/compulsive states, hysterical conversion and elaboration
Drug dependence and abuse, including alcoholism
Anorexia nervosa and other disturbances of body image
Psychiatric disorder in relation to mental handicap
Disturbances of sleep, appetite and sexual behaviour, not only as part of psychiatric syndromes
Organic mental syndromes

The weekly programme is complex and packed with commitments, and there is frequent concern expressed by some colleagues that not enough time is left for bedside and out-patient clerking and other clinical contacts between students and patients.

The in-patient units are at Springfield Hospital (a large adjacent catchment-area psychiatric hospital) where most of the teachers have their beds and where two professorial units are represented; and at Atkinson Morley's Hospital where the other professorial unit is situated. Atkinson Morley's Hospital has no catchment area commitment and is, in the main, a place of tertiary referral. It includes an eight-bed anorexia nervosa unit and a sleep laboratory. The unit is run on milieu lines, with an emphasis on behavioural and dynamic psychotherapies as a background to other treatment methods.

The students (20–25 at a time at present) are divided into two groups, which rotate between the two hospital attachments half way through the firm. Within the two hospitals, they are again split up into groups, usually comprising two students, and then attached to individual firms. Atkinson Morley's Hospital can no longer take all students as the numbers have increased, and adjacent psychiatric hospitals such as Long Grove work in tandem and are much appreciated by the students who go there. Each student has a senior registrar/lecturer supervisor, whose job it is to be available and to ensure that the student covers the core nosography, presenting each kind of case listed on a checklist which he carries with him. The supervisor in the first attachment also ensures that the student engages with one particular patient, who has captured his interest and whose presented case will comprise part of that student's end-of-firm assessment. The student should write this case up in detail, including reference to treatment and outcome, and with some reference to background literature.

Students attend relevant ward rounds and out-patient clinics and can join in domiciliary visits. The related clerkship is regarded as the important core of their attachment to the firm, and within it they are often called upon to present the cases. On Wednesdays, they attend a one-hour lecture as part of the systematic lecture course given within the firm, which is embedded in a more general lecture programme. On Fridays, they attend for a series of lectures (complementing the Wednesday lectures) and seminar presentations; these latter are organised by themselves under supervision. Attendance at lectures varies between 60–100 per cent. Outside visits are made to a prison, where they have an opportunity of observing forensic psychiatry services, and to a regional alcoholic unit.

Psychiatry of mental handicap and psychogeriatrics

These are taught while the students are at Springfield Hospital, where they come into contact with the relevant professorial units and engage, in successive small groups, in a week-long programme, interleaved with other aspects of their clerkship. This new arrangement is one which they appreciate, especially the community and domiciliary aspects, where they have special opportunities to observe and participate. However, it demands a great deal of teacher time and is being reviewed because of this.

Child psychiatry

This is taught (and examined) within Paediatrics.

Human sexuality

This is taught as part of a course organised with the

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Academic Department of Obstetrics and Gynaecology and is the responsibility of a jointly appointed part-time lecturer, who is a general practitioner with a clinical practice within the field of sexual dysfunction. The course runs over a six-month period and requires that students rotate in a six-month subcycle between the two subjects, within the year long package referred to earlier. It begins with a day-long exposure of the student to films portraying a wide range of sexual behaviour, and is lecture/seminar-based thereafter. As a course, it is still evolving and is valued by the majority of students, although some find it too provocative and disturbing. The aim, of course, is to help such students engage in and develop some understanding of the subject and to this end, there is a strong seminar basis to the course (Stanley, 1978).

Psychotherapy

Psychotherapy is taught from a number of perspectives. Within individual firms students may come into contact with various forms of behavioural psychotherapy, and this will allow them to amplify a core knowledge derived from the lecture/seminar programme. What is traditionally called dynamic psychotherapy is taught mainly within their clerkship at Atkinson Morley's Hospital, since the geographical split has presented some difficulties in organising this aspect of the course. Students are encouraged to respect the power of good psychotherapy in its various forms. They are reminded that individuals are open to influence through interpersonal transactions, and that a major contribution to this may come from the role occupied by those involved. Moreover, as psychotherapy is an attempt to harness such learning and unlearning for the purposes of symptom relief and personal growth in appropriate patients it can, like most potentially effective interventions, cause harm if misapplied. This teaching works best when it is based on difficulties they are currently encountering with patients in whose assessment and care they are involved.

Research

Students are sometimes involved in this and occasionally they come along enthusiastically, asking to be allowed to conduct some small piece of research. If possible, they are accommodated. We also encourage them from the beginning of our contact with them in the basic medical science course, to consider becoming paid volunteer normal subjects in our research such as the sleep laboratory.

Assessment

Assessment of the students' performance on the firm takes a variety of forms. The consultants who have been involved in the student's clerkship grade the student and make any comments they wish. The student's check list, coupled with tutor's comment, is also fed in. Towards the end of the firm, the students sit an MCQ examination involving 30 questions, and the results of this are taken into account, although its main intention is to introduce them to the concept and nature of such questions within psychiatry. On the last day, each student undergoes a half-hour individual assessment by a pair of examiners (teachers within the department), which involves 15 minutes devoted to discussion of the case presentation (previously submitted and read by the examiners), coupled with a 15-minute viva. This test of their presentation of their basic clinical skills is taken very seriously by the students who know they must perform adequately.

All these comments and gradings are condensed into a final grading and comment, which is passed on to the School and also fed back to the student. Unsatisfactory performance, especially within the end of firm assessment, leads to the student not being signed up and he or she may need to repeat the course or, more often, some part of it relevant to his or her revealed weaknesses, e.g. three or four weeks' extra clerkship, with intensive supervision from the tutor. Usually, they will have to resit the end-of-firm assessment; this happens to one or two students each year.

At the end of each firm, students are encouraged to comment critically and anonymously about the course. They do so by filling in a form, on which all components of the course are itemised and which leaves space for other remarks they may wish to make. This information is fed back to those of us who organise the firms and to all teachers, and influences our continuing attempt to improve the teaching programme. In particular, this is examined twice yearly at formal meetings of the departmental teachers and tutors.

Psychiatry electives

Opportunities for electives exist mainly in the UK and North America, and about five per cent of students undertake them.

University Examinations

Once the student has been signed up, he is eligible to sit his University final examination in psychiatry which comprises two sections. Firstly, at the end of the year-long block, the students sit written examinations in obstetrics and gynaecology, paediatrics, and psychiatry. In psychiatry, the examination comprises a two-hour paper, embracing 50 multiple choice questions and three out of six essay questions. The examiners are both internal and external. If the student fails in any one of these subjects, he may achieve compensation in the usual way, after discussion between all the examiners, or he may have to resit the relevant part six months later. The external examiners' views are held

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as overriding in such cases in respect of the relevant subject. Last year, there was one such resit in psychiatry.

The successful students then move on to their senior clerkship and electives. At a further stage, they will sit written examinations in medicine and surgery. At the end of their course, they will sit their final clinical examinations. Here, psychiatry and paediatrics are included within medicine, and we are currently experimenting with its pattern. The maximum time available for the exam is 90 minutes which allows, for instance

(a) 20 minutes for a viva involving two examiners from medicine, one from paediatrics, one from psychiatry and one from social medicine;
(b) a 35-minute clinical examination in medicine, in which our colleagues in medicine are concerned that the students focus on their basic clinical method;
(c) a 35-minute clinical examination in either paediatrics or psychiatry.

Half the students therefore have a final clinical examination in psychiatry, and we have devised a series of short and medium length psychiatric cases for this purpose, e.g. requiring the student to assess the personality of one patient, aspects of the family psychopathology in another, the suicidal risk or some other aspect of prognosis in another, the memory or affective status of another. Sometimes, he is given some basic and lead-in information. This last year, we reverted to the system instead of every fifth student having a long psychiatric case, another one fifth having a long paediatric case, and the remainder having long medical cases. We are continuing to experiment, but I have a preference for the former style, though it does create organisational problems.

Conclusions

In our experience many students begin their careers with an interest in psychiatry and one of our tasks is surely to avoid putting them off. At the same time we must aim at enabling the majority to sustain and develop such an interest as will stand them and us in good stead when they enter general practice or other clinical specialties.

To this end we need to reduce in the student's mind the potential for dissonance between psychiatry and the rest of medicine, especially bearing in mind the ambivalance of some of our colleagues in medicine towards the subject, and with which negative elements he may otherwise readily identify. If we can achieve this he is less likely to reject the relevance of the social dimension of disease. Then again, any demonstrable teaching and research links we have with such apparently different basic science departments as pharmacology, sociology, biochemistry and psychology can assist. Within it we can hope in true university style to concentrate the student's mind whilst broadening his imagination.

Within our own school I believe we could gain in our impact if we had more resource to contribute to our liaison service and if students were able to retain some long term though necessarily attenuated contact with one or two patients with whom they had been engaged on the firm. Such attention to longer term treatment and outcome is probably equally relevant to all their clerkships and requires an important shift of general curriculum policy if it is to be implemented.

I also believe that we would gain if we could reduce the amount of fixed didactic teaching in the main clerkship. This could arise through the provision of slide/tape material and handouts which could then be the basis of more informal seminar teaching allowing more active engagement of the students in considering the subject matter under scrutiny. This though is hard work for us and them.

We have yet to work out, in my view, the best balance of contributions from our own subject to some of the areas in which we teach e.g. mental handicap, geriatrics, sexual dysfunction, behaviour therapy. In such respects psychiatry overlaps for instance with paediatrics, community medicine, geriatrics, general medicine and clinical psychology.

However, hopefully medical students will continue to be the kinds of people who are interested in individuals rather than social systems, and in my view this personal and clinical interest, buttressed by adequate understanding of the former, needs to be nourished above everything else.

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