THE ROLE OF PSYCHIATRY IN THE MEDICAL CURRICULUM

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A great deal has been written in the past decade about the role of psychiatry in the medical curriculum. What should be taught? How should it be taught? When should it be taught? By whom should it be taught, and even why should it be taught at all?

Tredgold[1] advocated the integration of psychiatry into the curriculum in the American style. Curran[2] believed that the subject 'is best taught by the traditional system of apprenticeship in both the outpatient and inpatient departments, in just the same way as other branches of medicine are taught'.

Rodger[3] argued that the ultimate indication of success in incorporating 'mental health' teaching in the curriculum would be the disappearance of the psychiatrist as a teacher except for his specialized role as an instructor in the techniques of psychotherapy and the diagnosis and treatment of psychiatric disorders. It is difficult to evaluate these different points of view either in their own right or in relation to the undergraduate, graduate, or postgraduate phases of psychiatric education. Fortunately, in practice the methods of psychiatric teaching in our medical schools resemble each other more closely than might be expected, but it would be of value at this stage of psychiatric development to pool our experience in an attempt to reach agreement on our objectives.

Study in depth, whether in the humanities or the sciences, develops scholarship, sound judgment, and a method of approach applicable to problems in all fields. We must therefore be on our guard against superficial survey courses in so-called general education and the substitution of trade skills for basic scientific concepts. On the other hand, as Loeb[4] has pointed out, to place unbridled emphasis on research and thus engender the separation of scientific investigation from clinical medicine, would set the clock back and destroy the development and cultivation of the 'physician-scientist' whose dominant role in academic medicine must be maintained.

It is generally agreed that the medical curriculum is far from satisfactory and it is probable that the specific problems of psychiatry can best be viewed against those of the curriculum as a whole. Hill[5] said that medical education and vocational training to be a doctor are now seen to be two roles, which are not necessarily compatible. There are many types of doctor, many types of career, and it is evident that the range of scientific knowledge related to medicine is now so extensive that it cannot be comprehended by a single mind. He said it may now be usefully asked: what are the elements in the student's experience which contribute to the acquisition of scientific education?, what are the elements which provide him with vocational training for a particular career?, and what are the elements which encourage him to become a technician, preoccupied with the acquisition of skills? He concluded that the present trend is to confine scientific education to the preclinical years, the acquisition of technical skills and knowledge of them to the clinical years and postpone vocational training for a career in medicine until after registration. The breaking up of medicine into numerous specialties has favoured this process and has made it progressively more difficult for the student to learn about patients as persons adapting to an environment. Psychiatry must not, as yet another specialty, worsen this situation.

Change in Outlook

A remarkable change in outlook of the medical profession towards psychiatry has taken place in recent years, and it is now accepted that there is mental illness as well as physical illness and that both are entitled to medical care. It must, however, be admitted that, as Ellis[6] has said, the medical profession's new awareness of psychiatry is based much more upon a realization of the need for it than upon any belief that this need can be effectively met. This is important because when one comes to analyse educational objectives in relation to psychiatry, it is undeniable that the inculcation in the student of proper attitudes towards it is the greatest single objective. The acquisition of knowledge and skill are also objectives, but exactly what content of each should be offered to the undergraduate is by no means agreed.

The scheme proposed by Stengel[7] known as the Sheffield Plan, has been widely acclaimed and has received the approval of the British Medical Students' Association.[8] This course is called a 'Course on human behaviour' and is shared jointly by the psychologists and psychiatrists. There is no specific examination in psychiatry, but the final medicine paper is entitled 'Medicine including psychiatry', and the professor of medicine and the professor of psychiatry examine together in the final examination. At the other extreme are the recommendations of the WHO Expert Committee on Mental Health, and, as Hill[9] has pointed out, in their anxiety to introduce psychology and sociology into medical education, this Committee surely overreached themselves. In his opinion there is an attempt to represent too many points of view which can only bewilder the student and frighten the teacher. Attitudes, then, remain more important in psychiatry, more easily defined and perhaps more easily realizable as educational objectives in the undergraduate period than knowledge and skill. But, as Ellis[10] said, attitudes are as dependent on other clinical teachers as they are on psychiatrists. This is one reason why complete success in psychiatry can never be achieved simply by increasing the time devoted to it in the curriculum, although there is a constant clamour to do so.

TEACHING PSYCHIATRY

The teaching of psychology and psychiatry must be seen against the background of the medical curriculum as a whole.

The medical curriculum today consists of four phases: (1) The preclinical or basic sciences; this phase is educational and is concerned with providing the students more with the way of using knowledge than with the knowledge itself. It is designed to teach him to reason, to think critically, and to acquire a scientific method of thought so that he may thereafter learn for himself. (2) In the clinical years the knowledge and skill which the student obtains cannot be comprehensive, but it is important that the attitude he adopts towards individual patients is by now a comprehensive one. (3) In the compulsory intern year the licensed graduate has a general comprehensive vocational experience, and (4) later in his postgraduate studies, he should be able to acquire all the necessary knowledge and skills required in his particular form of practice.

In teaching psychiatry, more than in any other subject, it is important to keep these four phases in mind in 'exposing' the student to the psychological component of medical education. Psychology is one of the sciences basic to medicine and should be taught alongside with the biological sciences on which it is inter-dependent. Apart from preparing the ground in psychiatry, Danziger[11] has stressed that the teaching of psychology in the medical curriculum appears to have three main functions: In the first place it is necessary to teach the medical student some scientific psychology as an antidote against various popular psychological fallacies which he is likely to share with the lay public. It should introduce him to the problem of individual differences and their statistical treatment, the problem of normality and the problem of personal inter-relationship. It should also prepare him to see *the person* in the patient and thus to function more effectively in his professional role, while it is agreed that a course of rather distinct topics might lack integration and might leave the student uncertain about the range and application of what he has been taught: it is felt that this difficulty could be overcome when these principles are reinforced and reapplied during the systematic lectures in psychiatry.

During the clinical years the student must acquire a holistic approach to the patient and learn how to apply reason to problems consisting of physical, psychological and social variables. In the fifth year the psychiatric department must be responsible for the introduction of the student to that knowledge which relates directly to psychiatry. It has been found

best to concentrate first and mainly on the psychoses and not to expose him to much theoretical psychodynamics, and no attempt should be made to teach him formal psychotherapy.

In the graduate period a more secure and mature student engages in responsibility for patients under supervision. In this period of apprenticeship more formal education may be given on the problems of neuroses and minor psychological disturbances than the psychoses. In the postgraduate period he has the simple objective of learning the knowledge and the skills relevant to a particular branch of medicine under the direction of senior full-time psychiatrists as I have discussed elsewhere.[12]

THE STUDENT

The non-White students at the University Medical School in Natal are made up of Coloureds, Asiatics and Africans who are being educated in Western medical traditions and in the English language medium. A scientific approach to physical and biological reality has been accepted by them in their preclinical years, but like White students their education about themselves as a person and other people as persons is not blended with scientific principles but is based on traditional, religious and moral myths which arise from their own particular cultural backgrounds.

Bertrand Russell said many years ago that what man wants is not knowledge but certainty. The escape into myth and fable to avoid this feeling of insecurity is not confined to primitive peoples alone but occurs in the most sophisticated races even if their folk-lore is clothed in scientific jargon. The medical student comes from a culture biased against the study of man by the same principles of observation and reasoning as are accepted for the study of physical and biological events. Our students are also emerging from adolescence, fearful of uncertainty, seeking facts and preferring didactic teaching, and without being aware of it, receiving training rather than being educated. It is against this rather confused background that psychiatry has to be taught in an environment where until recently it was widely believed that the neurotic and the mentally ill were just poor constitutional types—'the products of inferior protoplasm who mostly lacked guts and moral sense'.

The immature student requires a mature, wise and understanding teacher who, in discussing case notes, should bear in mind the student's limitations and individual mentality. He should keep his observations as close as possible to observed facts and avoid abstruse theories. In fact, the whole undergraduate teaching of psychiatry should be practical and clinical rather than theoretical. It is one of the defects of the present-day teaching in psychiatry that too much is left to registrars and teachers of similar status. Such teachers are not sufficiently senior to guide the students' development, with the result that the doctor enters practice ill-equipped to recognize and deal with the mental aspects of his patients' illness. It is perhaps with this thought in mind that the Expert Committee on Mental Health expressed the opinion that a full-time appointment should not necessarily exclude the possibility that the professor might (with advantage to his students) have a moderate consulting practice.

The present emphasis on the behavioural sciences in the medical curriculum is an attempt to prevent the student during his clinical years from remaining only interested in diseased organs and injuries—part of the man—and failing to experience the reality of the illness of the person. Psychiatry in its wider sense assists the students to develop this new approach by teaching them another way of thinking and reasoning about patients and by providing them with a theory of human behaviour. This is not strictly the concern of formal psychiatric instruction, but it is an important aspect of medical education which every doctor should possess, for without it the practice of medicine would be reduced from a profession to a technical level. Moreover, as Hill[13] has pointed out, only when our medical teachers have been educated to think and reason in psychological terms as easily and automatically as they do now in chemical and physiological terms, can the medical curriculum be reorganized in a more realistic way.

CONCLUSIONS

Our students are not interested in the fact that 40% of all hospital beds are occupied by psychiatric patients, but they would be interested in the means by which these beds could be emptied. Psychiatry is on the march, and it is essential that our teachers and young scientists in this field should make tours of other teaching centres abroad in order to keep acquainted with the newer aspects of teaching and research. Fortunately, our South African College of Physicians offers Travelling Fellowships in Psychiatry for this very purpose. Here then is our challenge and our opportunity!

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