

COMMENTARY

# Undergraduate psychiatry education: the challenges ahead

## COMMENTARY ON... TEACHING MEDICAL UNDERGRADUATES<sup>†</sup>

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### SUMMARY

This commentary discusses the key issues facing undergraduate psychiatry teaching and the factors inhibiting psychiatrists' roles as medical educators. Potential solutions to allow psychiatrists to fully embrace their teaching role are presented. A particular focus is on enhancing teaching skills, challenging student perceptions of psychiatry and ensuring that teaching is protected, valued and appropriately rewarded. This requires a concerted approach on individual, organisational and policy levels.

### DECLARATION OF INTEREST

None.

<sup>†</sup>See pp. 104–109, this issue.

The word 'doctor' comes from the Latin *docere*, meaning 'to teach'. In this issue of *Advances*, Bennett Eng (2011) has produced a summary of the responsibility of doctors to teach medical students. However, there are broader issues impeding this obligation and these must be examined for psychiatrists to fully engage in their 'role' as medical teachers. The striking variation between medical schools in the percentage of graduates choosing a career in psychiatry suggests that difficulties exist in some universities (Goldacre 2005). In a study of UK medical schools several problems in psychiatry education were identified (Dogra 2008), as shown in Box 1. This article will examine the important challenges that exist and discuss potential solutions.

### Improving teaching skills

The quality of teaching skills among psychiatrists is a key issue in undergraduate education. Although National Health Service (NHS) psychiatrists deliver most of the undergraduate psychiatry teaching in the UK, few consultants and only 30% of psychiatric trainees have formal training as educators (Bramble 1991; Dinniss 2007; Karim 2009). *Good Medical Practice* (General Medical Council 2006: p. 14) states: 'If you are

involved in teaching you must develop the skills, attitudes and practices of a competent teacher.' Not all psychiatrists will have access to or funding for teaching courses or indeed will need formal teaching qualifications. Box 2 shows a stepped approach for developing skills that are proportionate to the level of teaching activity and responsibility.

### Knowledge of the undergraduate psychiatry course

Although the core curriculum (Royal College of Psychiatrists 2009a) may encourage standardisation of course content, there is marked variation in the structure, content, length and assessment methods used in UK medical schools (Wilson 2008; Karim 2009). Being familiar with these aspects of your local course will make the process of teaching more focused and relevant for the student and will prevent the teaching 'overlap' described by Eng. This requires effective communication between the teacher, course lead and course administrator.

### Psychiatry teaching guides

Eng concentrates on the American Psychiatric Association's teaching guide (2002), but there are several clinical teaching guides specific to psychiatry, as shown in Box 2. These give useful, practical advice on teaching medical students in various settings such as in-patients, out-patients, on home visits and when on call.

### BOX 1 Problems in undergraduate psychiatry education

- Supply and quality of teachers
- Stigma and students' attitudes towards psychiatry
- Conflicts of time (service v. teaching)
- Lack of control of funding
- Lack of support from academic department
- Status of teaching psychiatry

(Dogra 2008)

**BOX 2 A stepped approach to improving teaching skills****Knowledge of the undergraduate psychiatry course**

- Course structure, lecture programme, curriculum, learning outcomes and exam format

**Psychiatry teaching guides**

- *Core Trainees' Guide to Clinical Teaching with Medical Students in Psychiatry* (Royal College of Psychiatrists 2009b)
- 'How to win the hearts and minds of students in psychiatry' (El-Sayeh 2006)
- 'Time-efficient clinical teaching' (Lydall 2011)

**'Teach the teacher' courses****Medical education postgraduate degrees**

- Certificate, diploma, masters

**'Teach the teacher'**

'Teach the teacher' courses are provided by universities or postgraduate deaneries and usually cover learning theory, lecture skills, small-group teaching, individual teaching and giving/receiving feedback. It has been recommended that these courses be limited to a small number of participants, occur during normal working hours over 1 or 2 days and be open to all specialties (Gibson 2000). However, several psychiatry-specific courses have been described (Brown 2003; Vassilas 2003). These courses have been found to increase teaching confidence, knowledge, self-rated ability and teaching behaviour at follow-up compared with control groups (Dennick 2003; Rubak 2008). The Scoping Group on Undergraduate Education in Psychiatry (Royal College of Psychiatrists 2009a) has made specific recommendations that 'all clinical teachers should have attended a minimum of a two day teaching course' (p.26) and some have described such courses as 'mandatory' in the context of General Medical Council revalidation (Swanwick 2009). Although these courses have increased in popularity, their availability varies markedly across the UK.

**Medical education postgraduate degrees**

There are more than 20 universities across all UK jurisdictions that offer medical education degrees. Most courses are modular with flexibility on which topics are studied. There are usually themes covering learning, teaching, assessment, course development and educational research. Courses generally start at certificate level with the opportunity for further study to diploma or Masters level. Some offer an element of distance learning and

three centres (Cardiff, Dundee and Edinburgh) run courses that can be completed entirely by distance learning. There is also variation in length, cost, reputation, focus on medical or clinical education and whether they have any external affiliation, such as with a medical Royal College.

**Stigma**

There is evidence that the attitude of medical students towards psychiatry before starting medical school is relatively positive (Maidment 2003). However, this decays during the first few undergraduate years with improvement, at least in the short term, during psychiatry attachments (Baxter 2001; McParland 2003; Maidment 2004). 'Bad-mouthing' or anti-psychiatry stigma among non-mental health clinicians and teaching staff may explain some of the deterioration in attitudes seen outwith the psychiatry attachment (Brown 2007; Eagles 2007; Oxtoby 2008). Although other specialties are not immune, there is a sentiment that psychiatry is a particular target, as in 'we all bash psychiatry' (Garg 2009). Students may initially view their psychiatric placement as 'low priority' (Dogra 2008), which could affect teaching morale. However, the attachment should be viewed as a crucial opportunity when attitudes can improve and career decisions can be influenced.

In addition to providing high-quality teaching, the factors that have been found to improve student attitudes should be enhanced. These include forming a close working relationship with the student, seniors (particularly consultants and senior trainees) offering encouragement, direct patient contact, emphasising the scientific basis of psychiatry and making sure that students witness patients getting better (McParland 2003; Maidment 2004). Some may argue that regular contact with psychiatry and psychiatrists throughout medical school may be most fruitful in confronting stigma. For example, Davies & Day (Royal College of Psychiatrists 2009a) advocate the integration of psychiatrists 'like a rash' in all areas of the medical school – from student selection and early medical science lectures to intercalated degrees, electives and final exams. In this way, negative perceptions of psychiatry and psychiatrists can be challenged at all stages of a student's career.

**Time commitments of teaching**

More than half of educational leads in psychiatry describe a 'conflict of time', where a lack of dedicated time for teaching in consultant contracts along with increasing service demands means that clinical demands usually take precedence (Dogra 2008).

With declining numbers of academics and increasing student numbers there may be further pressure on the teaching commitments of all psychiatrists. Attempted solutions have included formally integrating teaching commitments into employment contracts and upgrading the importance of teaching for distinction awards and discretionary points. Ensuring that time dedicated for teaching is timetabled, logged and reviewed as part of an annual appraisal may help to ensure that it is protected (Eagles 2005). For clinical academics, the research assessment exercise (RAE) ([www.rae.ac.uk](http://www.rae.ac.uk)) has meant that there is also pressure to focus on research rather than dedicating time to teaching. Although changes to the RAE have been advocated for many years, another solution is for universities to create specific honorary posts with dedicated teaching responsibilities distinct from research.

### Funding of psychiatric education

Clinical teaching in the NHS naturally incurs additional costs but the mechanism for administering this funding has been criticised for lacking educational governance, accountability and transparency (Eagles 2005). The NHS has traditionally received a 'lump sum' for teaching, with allegations that this has been used to fund clinical services rather than to enhance teaching. There is also a concern that because psychiatry teaching can be integrated throughout the curriculum and is more community based, it may be losing out to more technical disciplines or to acute teaching hospitals (Dave 2010). A more accountable system has been called for, with ring-fenced budgets for student education, audit trails and financial penalties for lack of transparency (Royal College of Psychiatrists 2009a). Funds could either reward good teaching, enhance sub-standard teaching or, if problems exist, be redirected to alternative institutions. It is proposed that strong leadership is required to influence policy, improve educational governance and foster closer working between universities and the NHS on quality assurance in teaching (Dave 2011). Good examples of this have already been described in various parts of the UK and can be replicated elsewhere.

### Conclusions

Teaching and training has been identified as one of the six key roles of a consultant psychiatrist (Royal College of Psychiatrists 2010). Eng has highlighted the teaching responsibilities of psychiatrists, but it is important to consider what factors obstruct this role. The problems facing undergraduate psychiatry education are diverse and require solutions, with

a particular focus on enhancing teaching skills, challenging student perceptions of psychiatry and ensuring that teaching is protected, valued and appropriately rewarded. Medical students are the future colleagues and potential successors of psychiatrists: the future standing of the profession lies with their effective education.

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