



editorials

TEIFION DAVIES AND PHILIP MCGUIRE

## Teaching medical students in the new millennium

Although psychiatry is a fundamental component of undergraduate medical training, it was not always so. Pressures to develop integrated, system-based curricula (General Medical Council, 1993) raise questions about the future of psychiatry as an undergraduate subject. In order to respond to these changes it is helpful to be aware of how psychiatry developed as an undergraduate topic, and of the nature of the present challenges (General Medical Council, 1997).

Formal teaching on mental diseases appears to have commenced in British hospitals in the late 18th and early 19th centuries, spurred on by the humanitarian aim of providing a supply of medical officers for the growing number of lunatic asylums (Porter, 1997). Guy's Hospital admitted patients with mental illnesses to its general wards during the 18th century, and another London teaching hospital, St Bartholomew's, established the post of Lecturer on Mental Diseases in 1871 (Medvei & Thornton, 1974). However, apart from visits by small groups of medical students to their local mental hospitals, most psychiatric education remained a post-qualification affair only to be undertaken by those who saw their future careers in the mental hospitals.

Teaching the psychological aspects of medicine to undergraduate students is largely a phenomenon of the second half of this century, taking its impetus from wartime experiences of neurosis and from the report of the Goodenough Committee in 1944. However, as late as 1961, Aubrey Lewis lamented the fact that, "the fusion of psychiatric education with the rest of medical teaching has not been fully attained anywhere" (Lewis, 1967). The fact that psychiatry gained a full place in the undergraduate medical curriculum in the ensuing 30 years can be attributed to several factors. These include: the growth of independent academic departments of psychiatry in the medical schools; the intellectual achievements of the psychiatric neurosciences; and the development of effective psychopharmacological treatments for mental disorder (Porter, 1997). Together with a growing awareness of the importance of the psychological aspects of health and disease, these factors gained for psychiatry a respectability equal to the traditional medical specialities.

What, then, has changed to threaten the place of psychiatry in the undergraduate curriculum? In Britain at least, the avowed intention of the regulating authorities (General Medical Council, 1993) is that the undergraduate core curriculum should be 'system-based' rather than 'departmentally-based'. This forced integration, implying that psychiatry and the clinical neurosciences share a common anatomical substrate, might encourage students to view psychiatry as concerned only with the

brain. While this is clearly an oversimplification, psychiatric research is increasingly illustrating the importance of neurobiology in psychiatric disorders, and a neuroscientific framework is perhaps the most accessible perspective for an undergraduate student to adopt. The intention to reduce the 'burden of factual knowledge' (General Medical Council, 1993) risks robbing psychiatry of its intellectual underpinnings which are found in sociology and psychology as well as the laboratory sciences. The emphasis on attitudes and skills rather than knowledge could demote psychiatry to the status of a humanising influence that merely facilitates the practice of the other medical disciplines, as predicted and criticised by Lewis (1967). However, the knowledge base in psychiatry is probably smaller than in some other specialities, so it may suffer less from its reduction than others, and its attitudes and skills are essential for all doctors (General Medical Council, 1997).

Much of the rationale for integration is based on the assumption of a traditional teaching base – the ward and clinic – in which the academic discipline and the clinical service are one and the same and where 'integrated' disciplines work side by side. This no longer holds for much of psychiatry where mental health services are disseminated in the community away from the academic centres (Muijen, 1993). Ironically, the success of psychiatry in developing community-based services militates against effective integration with hospital-based specialities. The logistic problems of students having to travel between hospital and diverse community settings might overshadow the quality of the teaching they receive. On the other hand, no discipline, not even primary care, is as well placed as psychiatry to enrich the learning environment by involvement of members of the multi-disciplinary team. Although this might require overcoming an initial reluctance to be involved in medical teaching, the multi-disciplinary team represents a potentially valuable educational resource and its members should be encouraged to view this role as contributing to their own professional development.

What are the opportunities presented to psychiatry by these changes, and what can be done to capitalise on them? The General Medical Council stresses the importance of devising and delivering a core curriculum as the focus of all levels of the medical course. Mental disorders are common in the community (Meltzer *et al*, 1995) and all doctors should have the knowledge and skills to detect them and initiate treatment: psychiatrists must ensure that they are fully, and richly, represented in the core curriculum and in any teaching based upon it. The new curriculum also emphasises the need for the student to learn through curiosity, with Special Study Modules



allowing in-depth study of areas of interest. This format might be particularly suited for psychiatric topics: medical students often find these of great interest but feel they are too far removed from the mainstream and likely examination material to merit precious study time. Psychiatric special study modules could allow them the time to pursue such interests.

The new curriculum places students in contact with psychiatric patients at a much earlier stage of their training than was previously the case. This permits psychiatric knowledge and skills to be inculcated while students are more receptive to new ideas, with the potential to inform their later practice. Many students form their ultimate career choices during their undergraduate course. By actively responding to the challenges of the new curriculum, psychiatry can contribute to a rich and rewarding educational experience without risking dilution of its own essential core values. In doing so, it will contribute positively to the next generation of doctors (General Medical Council, 1997), and ensure that it ultimately attracts graduates of the highest calibre.

## References

- GENERAL MEDICAL COUNCIL (1993) *Tomorrow's Doctors*. London: General Medical Council.
- (1997) *The New Doctor*. London: General Medical Council.
- GOODENOUGH COMMITTEE (1944) *Report of the Interdepartmental Committee on Medical Schools*. London: HMSO.
- LEWIS, A. (1967) *The State of Psychiatry. Essays and Addresses*. London: Routledge & Kegan Paul.
- MEDVEI, V. C. & THORNTON, J. I. (1974) *The Royal Hospital of St Bartholomew 1123–1973*. London: St Bartholomew's Hospital.
- MELTZER, H., GILL, B., PETTIGREW, M., et al (1995) *The Prevalence of Psychiatric Morbidity Among Adults Living in Private Households*. OPCS Surveys of Psychiatric Morbidity in Great Britain. Report 1. London: The Stationery Office.
- MUIJEN, M. (1993) Mental health services: what works? In *Dimensions of Community Mental Health Care* (eds M. P. I. Weller & M. Muijen), pp. 38–60. London: W. B. Saunders.
- PORTER, R. (1997) *The Greatest Benefit to Mankind*. London: Harper Collins.
- \*Teifion Davies** Director of Undergraduate Studies in Psychiatry, Guy's, King's and St Thomas' School of Medicine, Academic Department of Psychiatry, London SE1 7EH and **Philip McGuire** Senior Lecturer in Psychiatry, Institute of Psychiatry and Guy's, King's and St Thomas' School of Medicine, London SE5 8AF