Teaching medical students and recruitment to psychiatry: attitudes of psychiatric clinicians, academics and trainees

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Aims and method An online survey was used to examine the attitudes of clinical, academic and trainee psychiatrists on the delivery of undergraduate education and why students are not choosing psychiatry as a career. This paper explores whether attitudes to teaching psychiatry to medical students is a factor in poor recruitment to the specialty.

Results Overall, 390 psychiatrists completed the survey. All groups were highly committed to psychiatry education, but there were significant differences in attitudes that may have an impact on the delivery of medical student teaching, which in turn may influence recruitment. Five major themes emerged from the survey, the most dominant being stigmatisation of psychiatric patients and professionals by the medical profession. These divergent attitudes to teaching and stigma may be contributing to low levels of recruitment into psychiatry.

Clinical implications Education of the next generation of psychiatrists is a high priority and active measures are needed to increase commitment and enthusiasm in undergraduate education.

Declaration of interests None.

There is growing concern in British psychiatry about the poor rates of recruitment into the specialty.[1] There is no doubt that medical students' educational experience of psychiatry plays a great role in determining whether they choose a career in psychiatry.[2] But even when students' attitudes to psychiatry are affected positively during their psychiatry placement (in year 3 or 4 of the medical course), this effect can be short-lived and diminishes during their final year.[3] It is even more concerning that students entering medical school with an interest in pursuing a career in psychiatry change their minds during their time in medical school.[2]

The large majority of medical students will not become psychiatrists; for them a psychiatry clinical placement will be the only experience of psychiatric practice before they begin to work as doctors. This critical and essential training experience includes learning about the management of mental disorders, suicide, self-harm, violence, substance misuse, psychopharmacology, and treatment of those patients who have comorbid medical and psychiatric illnesses. More recently, there is also an emphasis on well-being and population health, and how to ensure that positive emotional states are protected and nurtured in the workplace and in family life. Recent changes in the organisation of mental healthcare, including more treatment in the community, preventive psychiatry, and psychosocial interventions, challenge conventional roles in medicine and might deter doctors who favour working in hospital settings. The way the skills and attitudes necessary for modern psychiatric practice are taught and developed will shape medical students' attitudes to psychiatry; as part of this learning experience, students will learn to deal with stigma towards psychiatric patients and the psychiatric profession.

At present, undergraduate education in psychiatry is delivered in a variety of ways across the UK by psychiatrists with either university or National Health Service (NHS) trust appointments.[4] These two groups have different types of job plans, different priorities, and different demands on their time. For instance, it has been reported that academic psychiatry departments are disinterested in teaching and concerned only with research, whereas NHS consultants are more focused on service demands.[5] This situation is not limited to psychiatry[6] but the way it is managed in psychiatric teaching and mentoring may be different.[7] To explore these attitudes towards teaching psychiatry, we surveyed clinicians and academics who are practising as psychiatrists in the UK. We asked their views on the delivery of undergraduate education and why students are not choosing psychiatry as a career.

Method

The questionnaire used in this study was devised following consultation with groups of psychiatry academics, clinicians and trainees. The views of these groups were gathered independently by the authors and all items raised were included in the questionnaire. The survey was given online using the Survey Monkey website (www.surveymonkey.com). The links were circulated to North East London Foundation Trust, East London NHS Foundation Trust, Northern Ireland, Cardiff (Wales) and also advertised nationally in the Royal College of Psychiatrists' member's e-Newsletter. Data were collected over a 3-month period. The participants were anonymous but were asked about their position, age, gender, year of qualification and primary post. Chi-squared analysis was used to test whether there were any significant associations between job type, age, gender and the responses for each of the separate 17 attitudinal survey items.

The questionnaire also included a free-text response question: 'Why are students not taking up psychiatry as a career?' Major themes were identified from the responses independently by two researchers (A.K. and N.D.) and coded systematically across all responses; frequency counts of the five emergent themes are reported with some verbatim examples.

Table 1 Age and primary role of participants

	N (%)
Role	
Trainee	138 (35.9)
NHS clinical staff	209 (54.4)
Academic staff	37 (9.6)
Age, years	
⩽35	130 (33.6)
36–45	123 (31.8)
46–55	89 (23.0)
⩾56	45 (11.6)

NHS, National Health Service.

Results

Our survey was completed by 390 people (38.5% women); their ages and roles are shown in Table 1. Table 2 shows the responses of the three groups to each of the attitudinal items. Significant differences ($P<0.05$) in responses between groups are shown in bold in Table 2.

A higher number of clinicians compared with academics and trainees agreed that they did not have time to teach medical students ($P<0.001$). Both clinicians (42%) and academics (47%) felt that teaching medical students did

Table 2 Percentage of each group agreeing with the survey item (significant differences in bold)

	%				
Survey item	Academics	Trust clinicians	Trainees	χ^2 (d.f. = 2)	*P*
It is important to have good teaching of psychiatry to medical students	97	98	100	2.79	0.250
I am interested in teaching psychiatry to medical students	95	95	99	3.0	0.224
I do not have time to teach medical students	**19**	**39**	**23**	**13.63**	**0.001**
Teaching medical students does not contribute to my career prospects	**42**	**47**	**21**	**23.7**	**0.001**
My participation in teaching is considered to be an important component of my appraisal	**83**	**62**	**78**	**12.6**	**0.002**
Psychiatry could be taught to medical students by primary care physicians as effectively as by psychiatrists	14	8	6	2.36	0.308
Medical students should be taught by those individuals who have identified teaching sessions in their job plans	**59**	**70**	**53**	**10.24**	**0.006**
It is the responsibility of all doctors to teach medical students and should be an integral part of their work	**83**	**80**	**91**	**8.6**	**0.013**
Teaching of medical students should be mainly carried out by specialist trainees	**17**	**13**	**38**	**30.0**	**0.001**
Clinical academics whose sole work is education should be appointed	**65**	**41**	**42**	**7.45**	**0.024**
NHS consultants with specific responsibility for teaching undergraduates should be appointed	81	75	70	3.89	0.143
All those undertaking undergraduate teaching should receive training in educational methods	**71**	**82**	**90**	**8.23**	**0.016**
Clinical academics should take the lead for the organisation of undergraduate teaching	76	67	61	3.02	0.221
The psychiatry curriculum should be led by university psychiatry departments	86	77	82	2.22	0.329
My local academic psychiatry department is supportive of undergraduate teaching	91	83	88	2.26	0.324
The trust where I work is supportive of undergraduate teaching	75	83	86	2.60	0.274
Educational research is as important as clinical and scientific research	**53**	**75**	**77**	**9.00**	**0.011**

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not contribute to their future career prospects compared with 21% of trainees ($P<0.001$). Fewer clinicians considered teaching to be a significant component of their appraisal compared with trainees and academics.

There were also differences on items on who should be teaching psychiatry: a higher number of clinicians agreed that this should be carried out by individuals who have identified teaching sessions in their job plans. More trainees proposed that it was the responsibility of all doctors to teach medical students and that this should be carried out by specialist trainees. More academics believed that academics with dedicated full-time teaching status should be appointed. Trainees and clinicians agreed that those undertaking undergraduate teaching should receive training in educational methods. A significantly lower proportion of academics agreed that educational research is as important as clinical and scientific research.

Only about 39% of respondents answered the open question: 'Why are students not taking up psychiatry?' The responses were coded to show the five dominant themes that emerged (Box 1).

Box 1 Views on why students are not taking up psychiatry

- 57% – Negative attitudes towards psychiatrists from other doctors and health professionals
  - 'Surgeons think that to be a psychiatrist you need to be weird'
  - 'Other specialties think that you don't really need to be a doctor to work in psychiatry'
  - 'Psychiatrists are seen as a laughing stock and in a dead-end specialty'
  - 'Stigma within the medical profession that psychiatry is somehow less important than other medical specialties'
- 40% – Used the phrase 'stigmatisation of psychiatry'
  - 'Psychiatry is still stigmatised and ridiculed as a specialty by many'
- 39% – General stigma associated with mental health disorders
  - 'Patients are seen as useless'
  - 'Students are (unnecessarily) frightened of psychiatry patients chronic or challenging due to personality traits'
- 37% – Poor teaching and role-modelling from psychiatrists
  - 'Far too much reliance on "self-directed" learning'
  - 'Less visibility of psychiatrists in undergraduate teaching generally'
  - 'Experience of jaded or cynical trainers'
  - 'Poorly organised psychiatry attachments with little exposure to patients, carers and services'
  - 'Neglect by trainers during attachments'
- 26% – Psychiatry is not medical or scientific enough
  - 'Psychiatry not seen as "proper" medicine'
  - 'Seen as the soft option'
  - 'There isn't enough science in psychiatry'
  - 'Work isn't measurable'
  - 'Psychiatrists seen as too lazy to work in "real" medicine'
- 26% – Poor morale and role definition among psychiatrists
  - 'Psychiatrists moan a lot'
  - 'Psychiatrists have diminished contact with patients as a result of New Ways of Working'
  - 'Poor state of British psychiatry'
  - 'Flattened hierarchy'
  - 'Students and others can't work out where doctors fit in'

Discussion

A limitation of this study is that these are the views of those who responded to an online survey and they may not be a representative sample of the views of all UK psychiatrists. Our questionnaire was developed for this specific survey, having been generated in pilot work, and although this is a reasonable approach to use when there is no consensus, replication using these questions in other centres is necessary. However, a strength of the study is that a large number of psychiatrists responded to the survey and there was a good distribution between trainees, NHS clinicians and academics similar to that among psychiatrists in the UK. There was also a high consistency in the views expressed.

The overwhelming majority of respondents endorsed the statement that good teaching in psychiatry is important and 80–90% expressed a personal interest in teaching; however, a large proportion felt that they did not have enough allocated teaching time and that teaching medical students did not contribute to their career progression. Lack of time was endorsed mostly by those with NHS clinical consultant posts and probably reflects the previously reported general lack of realistic job planning to allow time to teach students, including preparation and managing feedback from students.[5] Creation of NHS teaching consultant posts is one approach to improving this situation and a majority endorsed this choice, but, in the current financial climate, this may become an unwelcome option.

It is encouraging, although perhaps not surprising, that the younger the participants, the more keen they were on teaching. This could be due to the proverbial 'enthusiasm in the young and cynicism in the old', but it could also reflect that they themselves received better teaching than their older counterparts and place a greater value on it. The question is – should these enthusiastic young trainees be delivering a larger proportion of the teaching? They themselves think they should but again this is often difficult because proper allowance for teaching is not made in their job plans. This is very unfortunate, because the General Medical Council has stated clearly that it is a requirement of all doctors to participate in teaching[8] and as future consultants our trainees will be delivering most of the clinical teaching. It is a vital part of their own training to gain skills and experience in clinical education. Also, junior

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doctors may make more effective role models to inspire students to choose a career in psychiatry.

Psychiatry is increasingly taught in primary care settings.[4] This may help to reduce stigma, and also tailor teaching to the majority of medical students who will work in primary care; however, some specialists think psychiatry would then become a postgraduate-only specialty for those choosing this career path. General practitioners (GPs) would then not experience in-depth training in modern psychiatric practice, thus, perhaps, permitting splits between specific services and persistence of stigma in other settings. Survey participants had strong views that psychiatry could not be taught as well by GPs as by psychiatrists – this is in contrast to the views of GPs where over a third felt competent to teach psychiatry;[9] however, both groups are probably considering very different types of psychiatric treatments, patients, and levels of need and complexity. The shift of mental health policy to primary care and public health also argues for new approaches to psychiatric teaching and practice, beyond the relatively smaller number of patients with the most complex and challenging illnesses.

Views were generally similar in the three groups of psychiatrists but there was one obvious difference between academic and trust respondents on attitudes towards educational research. Academics rated this as being less important than scientific research and this may reflect the fact that the standard of educational research varies widely and even high-standard research will rarely be accepted by high impact factor journals. The driving force in most academic departments is research performance measured by research spend and publications in high-impact journals of original data of international importance. This often relegates teaching activities to lower priority tasks and may also explain the lower level of enthusiasm in academics for posts that are purely educational. However, there is a recently growing recognition that undergraduate medical education needs to be prioritised to nurture future academic clinicians and address the wider crisis in academic medicine.[4]

It is concerning that, when asked why students do not choose psychiatry as a career, more than half of survey respondents specifically cited the stigmatisation of psychiatry as the greatest factor. Many of our respondents referred specifically to surgeons as putting down the profession. There are as many jokes about surgeons as there are about psychiatrists but surgeons do not complain about being stigmatised or face a crisis of confidence. Perhaps our own perception of how we are regarded is what puts the students off? We are in a strong position to overcome any stigmatisation of our profession and we need to take an active stand. Stigma comprises ignorance, prejudice and discrimination.[10] By educating our students properly we can eliminate ignorance. The current advances being made in psychiatry are unprecedented. We are now gaining a deep understanding of how biological, psychological and environmental factors interact to cause mental health disorders. Many of the disorders that we treat are major public health problems, for example, depression is predicted to become the second most common disease burden by 2030.[11] Negative attitudes resulting in prejudice are based on the perceptions that psychiatry is not medical or scientific and that prognosis is hopeless[12] – but who else can change this view among our colleagues if not psychiatrists educating the next generation of doctors? There are some obvious problems facing British psychiatry, such as the downgrading of medicine in our treatment practice[13] and psychiatrists' own beliefs that the prognosis of patients is poor,[12] which need to be addressed before we can begin to inspire our medical students to enter the profession.

We believe that only a change in our own attitudes to psychiatry and a commitment and enthusiasm to educating our medical students is going to change the attitudes of the next generation of doctors.

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