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correspondence

A policy to deal with sexual assault on psychiatric in-patient wards

Lawn & McDonald outline a clear policy that they have developed for dealing with sexual assault on in-patient psychiatric wards (*Psychiatr Bull* 2009; **33**: 108–11). I welcome their account and in particular their flow chart and the accompanying guidance for its use. In their references they list the Royal College of Psychiatrists report CR52 *Sexual Abuse and Harassment in Psychiatric Settings*. I regret that they do not refer to the subsequent College Report CR145 *Sexual Boundary Issues in Psychiatric Settings* (online only) published in August 2007. To quote from the College website: 'This revision of the original College Report CR52: *Sexual Abuse and Harassment in Psychiatric Settings* . . . has led to a review within a wider remit, taking into account major developments in the legal framework within which patients are treated and encompassing a broader discussion on sexuality. Issues of capacity and consent are relevant for all areas of care, and psychiatric professionals have to balance principles of autonomy and protection. Particularly relevant in this context are the Human Rights Act 1998, the Sexual Offences Act 2003, the Mental Capacity Act 2003, and additional legislation regarding standards of care for both adults and children. The area is one of high risk in terms of likelihood and impact because of the vulnerability of the patient group. Recommendations are made in the light of the Kerr/Haslam Report (2005), the Patient Safety Observatory Report 2 (NPSA 2006), and the government report Safeguarding Patients (2007)' (www.rcpsych.ac.uk/publications/collegereports/cr/cr145.aspx).

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More than just problems with problem-based learning

Problem-based learning (Skokauskas N, *Psychiatr Bull* 2009; **33**: 117) is used in 'new' curricula since the publication of *Tomorrow's Doctors* by the General Medical Council in 1993. It allows students to solve problems and can integrate teaching across specialties and between clinical and basic science elements (horizontal and vertical integration). This promotes 'deep learning' and students using this learning style perform better in clinical examinations.[1] This learning style will not suit all students, but allowing the opportunity to adopt alternative learning styles is important. It also facilitates adult learning which is required in clinical practice.

McParland *et al*[1] showed that using problem-based learning led to an improvement in both written and viva examinations compared with traditional methods for teaching psychiatry, consistent with previous studies. This approach also had greater student satisfaction ratings.

In view of these factors, problem-based learning and other newer methods are used as part of an integrated curriculum in most medical schools.[2] This ensures students develop the skills fostered by problem-based learning and those of a traditional curriculum.

Although 'psychiatry changes rapidly', advances are not restricted to this specialty and it is thus difficult to use this as an argument against using problem-based learning in psychiatry. This would lead to less rather than more integration as intended by *Tomorrow's Doctors*, to the detriment of the specialty.

It is also contradictory to argue for traditional lecture methods while criticising problem-based learning as problems may be set by one person, which is likely to be the case with lectures. It has been shown that problem-based learning delivered by non-experts leads to a reduction in examination performance,[3] thus experts such as Dr Skokauskas' 'charismatic professors' should be encouraged to facilitate problem-based learning sessions. The lack of exposure to a 'charismatic' figure, postulated to reduce student's enthusiasm for pursuing psychiatry as a career, can be addressed using an integrated approach. An alternative way of attracting students to psychiatry is for teachers to encourage them to join the Royal College of Psychiatrists as Student Associates (www.rcpsych.ac.uk/training/students.aspx).

1 McParland M, Noble L M, Livingston G. The effectiveness of problem-based learning compared to traditional teaching in undergraduate psychiatry. *Med Education* 2004; **38**: 859–67.

2 Wilson S, Eagles JM. Changes in Undergraduate Clinical Psychiatry in Scotland since 'Tomorrow's Doctors'. *SMJ* 2008; **53**: 22–5.

3 Hay PJ, Katisikitis M. The 'expert' in problem-based and case-based learning: necessary or not? *Med Education* 2001; **35**: 22–6.

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Psychiatry benefits from problem-based learning

Skokauskas (*Psychiatr Bull* 2009; **33**: 117) restates several arguments against the use of problem-based learning in undergraduate medical education. We feel, as current problem-based learning tutors who were ourselves students on a problem-based learning course, that we can offer a more positive view.

The author seems to imply that problem-based learning cases replace the clinical experiences that have traditionally shaped students' learning. In our experience, cases (often meticulously refined over several years) act to support and guide clinical learning, as they can bring to the fore ideas and issues that may rarely be apparent to students on clinical placements.

Skokauskas suggests that problem-based learning courses are inefficient, since traditional curricula may cover more material over the same time. But of course including a subject in the curriculum does