FORUM - PSYCHIATRY IN MEDICAL EDUCATION

A core curriculum in psychiatry for medical students

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The World Health Organisation estimates that 500 million people worldwide suffer from some kind of mental disorder. Many of these conditions go undetected, or if detected remain untreated. If this situation is to improve, all future doctors must be sympathetic to patients with psychological problems, able to detect mental disorder and treat simple cases, and aware when to seek specialist help. This need for effective education in psychiatry for all doctors is as great in developing countries as in developed ones. Indeed it is even greater in countries with poorly developed psychiatric services in which a greater proportion of psychiatric disorder has to be managed by doctors who are not psychiatrists.

What should medical students learn about psychiatry? The broad outline of a curriculum is agreed widely but it is less easy to reach agreement about the amount of detail that should be included. In the past the curriculum could be decided by reference to the work of a general practitioner but nowadays it is usual to provide some further postgraduate instruction for future general practitioners. Unless they work in a country in which students still enter general practice without further training in psychiatry, teachers now have to decide what the newly qualified `all-purpose' doctor needs to know. In broad terms the requirements are those referred to above: to understand the nature of psychiatric disorder, to detect it, to manage simple problems and to know when to arrange specialist help. Details will vary in different parts of the world, depending on patterns of morbidity, and on the way in which care is provided. However, the emphasis is likely to be on anxiety and depressive disorders, adjustment disorders, delirium, dementia and substance abuse; and on an understanding of the role of psychological and social factors in illness generally. It is useful to produce an annotated curriculum which relates what students have to learn to the problems that they are likely to meet when they begin work as doctors. This helps to motivate students and it restrains teachers from including excessive detail.

Medical students value clinical skills and among the most important are those involved in interviewing. Students need this skill to be able to recognize emotional reactions and psychiatric disorder, but the ability to interview and communicate with patients is the basis of all clinical practice. Interviewing skills are of several kinds: those needed to gather, to assess and to give information. Psychiatrists are not the only clinicians who can teach these skills, though they are specially important for their branch of medicine and they can claim special expertise in teaching them. It is usually best to arrange a coordinated course of teaching involving the psychiatric and other departments of the teaching hospital and primary care. Information giving skills are highly important and many complaints against doctors are concerned with a failure of communication. Despite this, students usually have fewer opportunities to learn the skills of giving information to patients than they have to practice collecting information from patients. Psychiatrists have an important part to play in teaching these skills, which like the information gathering skills are usually learnt more effectively when teaching is distributed between teachers from several medical departments.

Basic treatment skills include simple counseling and the ability to secure compliance with medication. Both are general skills, useful in all medical practice but psychiatrists bring special expertise to the teaching with an approach that emphasizes the need to understand the patient's background and personality. It is highly desirable that students should learn simple counseling skills but it is difficult to teach them except in small groups either with volunteer patients or using role playing. As with the ocher skills, the psychiatrist's involvement as a teacher does not require that the teaching should be wholly about psychiatric problems. Teaching during attachments to medicine, primary care or other subjects shows how counseling can bring about adjustment to physical illness and its consequences.

Attitude objectives are highly important in the teaching of psychiatry to medical students. Many students bring to psychiatry the unfavourable and stigmatizing attitudes towards patients that are common in the general population. Stigmatising attitudes and the fears of psychiatric patients that often accompany them, make it hard to involve students in the subject. Moreover if the attitudes persist, they lessen the future doctor's ability to detect and manage psychological problems regardless of the many facts about psychiatry

they have learnt. Unfavourable attitudes are most likely to change when students are involved directly in the care of psychiatric patients and their families, and when they are confronted with clinical problems that challenge their preconceptions. While students' stigmatizing attitudes usually diminish during the psychiatry course, they increase again when the course is over. Psychiatrists need to work closely with colleagues in other disciplines and attempt gradually to change attitudes to the subject within the whole of the medical school. A recent description of attitudes to psychiatry within a medical school showed how much psychiatrists still have to do to change them [1].

It is now generally acknowledged that medicine should be taught as far as possible through problem based learning. The method is appropriate for the teaching of psychiatry and can be used even in large classes provided that teachers have adequate time to plan and prepare teaching material. Individual learning needs to be reinforced by the ready availability of teachers and by group discussion, which is particularly importance in producing attitude change. Videotapes and computer programmes can help the student but psychiatry can be caught and learned effectively without expensive technology. If teaching aids are used, they should be produced locally, otherwise they have licde impact on students. 'thus problem based learning does not require fewer teachers than are needed for a didactic approach.

How should teaching be assessed? Whatever methods are used, they should evaluate the teachers as well as the students. It is now common practice to ask students to assess their teachers and this kind of audit helps to maintain standards and motivation. For the students a final `summative' assessment is necessary to ensure that they have reached the standard required by the university and by the registration authority. It is quite easy to assess knowledge in a final examination but more difficult to assess skills. It is even more difficult to assess attitudes at this time because students are seeking to please the examiner, and may hide their true opinions. Skills and attitudes can be assessed better during interim `formative' assessments carried out as the course proceeds. These formative assessments are valuable also as feedback to students about their progress and as a guide to their further learning. Assessments of factual knowledge can be pardy self administered but skills and attitudes have to be assessed by the teachers. Though unfavourable attitudes may not be a sufficient reason to fail students, they signify that the course is not achieving one of its major objectives.

Effective teaching requires commitment not only from the teachers but also from the medical school administration. It is self evident that the medical school should recognize teaching as its most important activity. Unfortunately the arrangements in some medical schools suggest that teaching is valued less than research when staff are appointed, when salaries are determined and when promotion is considered. Psychiatrists need to join other teachers in urging the medical school to demonstrate commitment to teaching by adopting policies about appointments and remunerations that show that teachers are valued highly. Psychiatrists also have a responsibility to convince the medical faculty of the need to provide adequate resources for teaching. Effective teaching requires a full time psychiatry attachment of about two months together with opportunities for teaching during attachments to medicine, obstetrics and pediatrics. If psychiatry is to be accepted as a major subject in the curriculum, psychiatrists need to contribute to the work of planning the whole medical curriculum and the general work of the medical school. These considerations add to the case for properly staffed teaching departments.

The World Psychiatric Association (WPA) report that is presented in the WPA pages of this issue of Current Opinion in Psychiatry shows the large measure of agreement that exists about the aims and methods of teaching, between psychiatrists from different countries. The differences between these teachers are in the resources that they have to achieve these generally agreed aims. It is an unfortunate paradox that the countries in which there are least resources for psychiatry teaching are generally those in which the need is greatest. As noted earlier this is because in these countries a greater proportion of psychiatric patients are likely to be seen by generalists because there are few psychiatrists. Since psychiatric disorder is no less frequent in developing than in developed countries, the low priority given to psychiatric teaching presumably reflects an assessment of the significance and eost eo the community of psychiatric disorders. The reasons why this judgment is unsound have been reviewed convincingly in a recent report [2]. The introduction to the report is by the former US president Jimmy Carter and his wife who wrote; `Even chose who acknowledge the importance of mental illness in industrialized countries all too often dismiss the problem as a relatively unimportant one in the developing world where overall health is so much worse. The information

summarized in this volume makes clear just how wrong is this position'. The same can and must be said about the teaching of psychiatry in developing countries. The publication of the WPA report provides a new incentive for psychiatrists to argue the case for their subject wherever they work.

References

1. Sinclair S. Making Doctors, an Institutional Apprenticeship. Oxford and New York: Berg, 1997.
2. Desjrlais R, Eisenberg L, Good B, Kleinman A. World Mental Health: Problems and Priorities in Low-income Countries. New York and Oxford: Oxford University Press, 1995.

Comments

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George N Christodoulou

The crucial issue to be considered when it comes to psychiatric training of medical students is the scope of the training. Which of the future needs of the physician should the training address? Which population needs should be satisfied? In view of the heavily loaded curriculum of medical schools, which psychiatric knowledge should be considered as essential? Is knowledge sufficient or should skills and attitudes also be considered?

It is indeed very fortunate that Professor Gelder, an experienced teacher, adopts this practical approach in his article. It is also fortunate that he recognizes that educational objectives should be differentiated in various parts of the world in keeping with different patterns of morbidity and care delivery systems. It is interesting, however, that he does not include schizophrenia in the list of disorders on which emphasis is likely to be put. Yet, in some pares of the world, early diagnosis of schizophrenia is an issue of great importance.

The emphasis on acquisition of skills and attitudes in addition to knowledge is of great importance and a prerequisite for appropriate management of not only psychiatric patients but any patient, for that matter. Although, as pointed out by the author, assessment of change in attitude is difficult, there are reliable instruments to monitor this change. Adopting (and maintaining) a positive attitude towards an ill person and more so towards a psychiatrically ill person certainly plays a more important role than learning psychopathology in textbook details.

The stigma attached to mental patients is sometimes extended to the people who care for them and the teachers of psychiatry. Some years ago reports appeared in which the image of the psychiatrist was depicted very negatively by medical students [1]. This seems to have changed recently. In addition there are reports showing that the personality of psychiatric trainees is in no way more defective than that of medical trainees [2].

Therefore, as well as acquiring knowledge and appropriate skills, it is important for the students to free themselves from the prejudices they carry concerning mental patients (and the people who care for them). Professor Gelder points this out emphatically.

The value of problem-based learning is rightly stressed in the article. The passive learning methods in huge lecture theatres, so popular in countries influenced by the German tradition and having served medical training for so many years, ate gradually falling into oblivion and new teaching techniques with the active participation of the student are being adopted.

Preparing teaching material for the medical students is of great importance. Again, one should first consider who is the recipient. We often forget this simple fact and many textbooks are full of detailed information

presented in a sophisticated way with a lot of scientific jargon. This is a consequence of our effort to respond a priori to die possible criticism of our textbook by colleagues. Yet, our textbook is not addressed to colleagues and we should free ourselves from the fear that our book will be perceived as naïve. It is the students' opinion that counts.

I have found Professor Gelder's article informative thoughtful and very well presented. I am glad I was given the opportunity to comment on it.

References

1. Nielsen AC, Eaton JS. Medical students' attitudes about psychiatry:
2. Implications for psychiatric recruitment. Arch Gen Psychiatry 1981; 38:1144-1154.
3. Christodoulou GN, Lykouras LP, Mountokalakis A, Voulgari A Stefanis CN. Personality characteristics of psychiatric trainees. In: Topics in Preventive Psychiatry. Christodoulou GN, Kontaxakis VP (editors). Basel: Karger; 1994; 137-142.

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Joseph T Coyle and Richard Mollica

Professor Gelder raises very important and timely points concerning education in psychiatry for physicians, particularly in developing countries. With the progressive eradication of infectious diseases, psychiatric disorders, primarily depression and substance abuse, are supplanting them as the major causes of morbidity in the developing countries. Furthermore, with the many millions of refugees resulting from local conflicts, psychiatric consequences of trauma and refugee status contribute substantially to the burden of psychiatric morbidity in the developing world [1). In spite of the epidemiologic evidence, the importance of psychiatric morbidity receives little attention in developing countries and diminishing support in developed countries. For example, aid agencies continue to focus primarily on issues related to infectious diseases and neglect the psychiatric sequels of refugee status [2,3].

As suggested by Professor Gelder, stigma may be the main barrier to the meaningful incorporation of training in skills for psychiatric diagnosis and treatment into medical curriculum education. Professional stigma, however, is probably more potent than cultural stigma. Thus, the opinion leaders in medicine were typically trained 20-30 years ago when psychiatric diagnoses were unreliable, treatments were poorly effective, and psychological theories of etiology were largely foreign to the medical model. The inappropriate persistence of this pessimism of leaders in academic medicine can limit the curriculum time allocated for psychiatric teaching and result in extinction of acquired psychiatric skills of trainees as they encounter internists and surgeons who view psychiatry through this two decade time warp.

This stigma in the senior ranks of medicine can most effectively be combatted by emphasizing the neurobiologic basis of serious mental and substance abuse disorders, which has emerged through neuroscience research over the last decade. For example, post-traumatic stress disorder is associated with structural changes in the hippocampus, and schizophrenia exhibits impaired frontal lobe function and diffuse atrophy of cortical structures. Furthermore, the efficacy in the treatment of severe psychiatric disorders now surpasses that of cardiovascular disease [4].

In developing countries where the emphasis must be on training primary care physicians in psychiatric skills, the curriculum must be designed to ensure ready mastery of the ability to diagnose and treat the most common psychiatric disorders [5). Psychiatry, fortunately, has developed highly reliable, phenomenologically based diagnostic instruments (DSM-IV and ICD-10) that are easy to apply for the diagnosis of common psychiatric disorders [4]. Furthermore, a new generation of psychotherapeutic drugs has been developed that are more effective and exhibit fewer and less serious side effects than the previous generation of psychotropic drugs. The symptoms of the most common disorders, including depression, post-traumatic stress disorder, anxiety disorders, schizophrenia and bipolar disorder, can be very effectively managed in most patients with psychotropic drugs.

Professor Gelder soundly recognizes that interviewing skills are the sine qua non of the patient-doctor relationship and are not unique to psychiatry. However, the linkage of `counseling' by primary physicians to skills in treatment of psychiatric patients is problematic. While psychiatry has long been tied to psychological interventions, especially psychodynamic psychotherapy, it may not be wise to focus on psychological interventions as the dominant skill in psychiatric treatment to impart to primary care physicians. First, psychotherapeutic treatment skills cannot be acquired in the limited time permitted for psychiatric education in even the most intense psychiatric curriculum for medical students and primary care physicians. Secondly, provision of psychotherapy and counseling is not cost-effective for primary care physicians with the limited time available for each patient; for example, the average primary care physician-patient `encounter' lasts less than 15 minutes in the USA. Rather, this treatment should be deferred to psychologists, social workers, counselors and clergy. Thus, an ancillary emphasis should be on education about mental illness and the development of psychotherapeutic skills in paraprofessionals, including traditional healers in developing countries, so that the primary care physician can work confidently with them.

There are new models emerging for the psychiatric education of primary care physicians in developing countries, even in areas of civil strife with large populations of refugees and displaced persons. For example, a curriculum has been developed and implemented for psychiatric training of primary care physicians in Cambodia (6) to assist them in the practice of culturally valid psychiatric medicine [7). A number of lessons have been learned from these new training experiences. While few psychiatrists exist in developing countries and the majority of mentally ill seek treatment from additional healers and primary care physicians, the primary care physicians generally do not feel socially empowered to care for `illness of emotional suffering'. This often leads to their superficial care of the patients, primarily through the palliative reduction of somatic complaints with drugs, without the establishment of a diagnosis of specific symptoms and adequate treatment of `root' causes of mental illness. This approach, which often leads to ineffective care, is also associated with the lack of awareness by physicians of the popular diagnoses for emotional suffering used by the general population. In developing countries, Western-trained physicians, while using modern biomedical approaches to the diagnosis and treatment of infectious diseases, will often be bewildered as to the proper treatment of psychiatric illnesses, which have been designated by their cultures as the primary domain of indigenous healers.

Fortunately, the seriously mentally ill seek the help of all available caregivers, especially the medical doctor when traditional healing fails. legitimizing the role of the medical doctor in caring for the seriously mentally ill is therefore a critical first step in any educational program. In order to achieve this goal, the learning by the primary care physician of a dual-diagnostic system of Western psychiatric diagnostic criteria and the local taxonomy of human suffering is essential. The Western-trained medical doctor muse be a repository of this knowledge for a better understanding of the mental health world of their patient. An intimate knowledge as well as traditional healing methods allow the physician to place their treatment within the entire range of options being simultaneously used by their patients. Finally, all physicians must be trained to assess the impact of sociodemographic factors (for example, gender, age, level of education), cultural factors (stigma and religious world view) as well as diagnosis-specific factors (for example psychosis) on the chief complaint, health seeking behavior, compliance with medication and most culturally effective approaches to the delivery of mental health services. Again; this type of understanding does not diminish but actually enhances the physician's ability to provide effective psychiatric treatment.

While tremendous advances have been made over the last decade on diagnosis, treatment and elucidation of the pathophysiology of psychiatric and substance abuse disorders, the next century presents the challenge of incorporating this rapidly advancing area of medicine into universal access to effective care. The first step for achieving this in developing countries is the creation of a curriculum that speaks to the most common disorders, their sociocultural contexts and their pharmacologic management.

References

1. Amnesty International. Human rights have no borders. New York: Amnesty International Publications, 1997.
2. Mollica RF, Jalbert RR Community of confinement: The mental health crisis in site two (displaced persons camps on the Thai-Kampuchean border). World Federation for Mental Health, February 1989.
3. Mollica RF, Donelan K, Tw S, Lavelle J, Elias C, Frankel M, et al. The effect of trauma and confinement on functional health and mental health status of Cambodians living in Thai Cambodia border camps. JAMA 1993; 270:581-586.

4. Health Care Reform for Americans with several mental illness; Report of the National Advisory Mental Health Council. Am J Psychiatry 1993; 150:1447-1465.
5. Ormel J, Von Korff M, Ustun TB, Pini S, Korten A, Oldehinkel T. Common mental disorders and disability across cultures: Results from the WHO collaborative study on psychological problems in general health care. JAMA 1994; 272:1741-1748.
6. Lavelle J, Tor S, Stedman W, MoNica RF, Sath S. Curriculum for Khmer mental health training and certification program on the Thai-Cambodian border. Boston: Harvard Program in Refugee Trauma, 1993.
7. Lavelle J, Tor S, Mollica RF AHden K, Potts L (editors). Harvard Guide to Khmer Mental Health. Boston: Harvard Program in Refugee Trauma, 1996.

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From time to time, medical education undergoes revisions and changes. At the beginning of this century, it was believed that given enough tact, care, and human sensitivity, the calling of the profession would endow almost everyone with the necessary skills for obtaining information from and delivering information to sick people. As time went on, these skills were shown to be far more complicated than a general beneficent attitude. It was shown, in fact, that the need to intervene~ or to treat a person may be dependent upon at least three different discourses: one based on personal suffering, one dependent upon expert knowledge, and one built upon interpersonal relations with others [1]. As it became clear, expert knowledge of a sensory type, favoured by positivistic science, is but one of the elements relevant to diagnosis, prognosis, and treatment. Medical sociological research uncovered the interpersonal locus of all suffering and the social construction of health and illness (2].

It is probably true that interviewing skills and attitude change are requisites in every branch of medicine. The need for experts to teach students about management and for elaboration through research stems from the fact that students have become technical tools. The technological imperative demands that they be taught by people who make their main job the furtherance of knowledge in the field of human behavior and mentation [3]. Professor Gelder has a good point when he stresses the need for valuing teaching in the medical school, but he would certainly agree that the teaching of psychiatry should be entrusted to people conversant with the process by which plain information is transformed into expert knowledge. This process is research, and the expectation is that everyone who understands the dynamics of his or her field is in a better position to teach it to others [4]. There would be no other reason, so it seems, to have the formal aspects of psychiatric training incorporated into the medical curriculum. The subtleties of careful interviewing, the ability to tackle emotional problems, the empathy necessary to understand the doubts and resistances of patients, when systematically developed by people who work with and upon them, are technical tools that every practitioner should have. In addition to that, the contents of psychiatry courses, the stuff of psychiatry proper, is less critical for the general practitioner, far more changeable due to fashion or progress and evidently less urgent to be converted into a necessary component of the psychiatric curriculum for general practitioners.

Distinguishing between formal and content aspects of psychiatry courses for medical students should also be viewed from another standpoint. When the necessary elements of a technique are learned, the rationale behind is also grasped and a way of thinking is added to education. Psychiatry is a medical discipline where medicine interfaces with many other aspects of the human social condition. To learn its systemic approach to illness and care, its importance for institutional organization and the alphabet of suffering in the psychological mode is far more important than to master a few facts soon to be replaced by other facts.

From the issues raised by Professor Gelder we single out two key points. First, that formal aspects of psychiatric training are more important than bare information. Second, that these aspects should be taught by people devoted to their continuous improvement through research.

References

1. Lolas F. Theoretical medicine: a proposal for reconceptualizing medicine as a science of actions. The journal of Medicine and Philosophy 1996; 21:659-670.
2. Lolas F. Meaning and the rhetoric of knowledge production. Transcultural Psychiatry London 1997; 34:91-94.
3. Lola's F, Br~utigam W. Psychosomatic medicine: a context for the teaching of physician-patient relationships. Health Communications and Informatics 1980; 6:624-627.
4. Lolas F. Research and teaching in psychiatry: Building up interfaces. Psychline (Inter-transdisciplinary journal of Mental Health 1997; 2:2728.

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The WPA Core Curriculum in Psychiatry for Medical students is a timely and much needed initiative, and Professor Gelder's article provides an excellent starting point for its discussion. This commentary raises some issues related to the needs and feasibility of psychiatry training for medical students within developing countries.

What should medical students learn about psychiatry? Their learning should obviously be relevant to the problems that they are likely to meet when they begin work as doctors and the way in which care is provided in their seccing Wide differences exist across the world in the structure and adequacy of general health and psychiatric services and the role a primary care doctor is expected to play. These, together with differences in the availability of teachers and the overall importance given to psychiatry, make the task of developing a common international core curriculum an extremely difficult one. The gap between the present situation within developed and developing countries is so large that what seems practically feasible with some additional effort within the former is too distant a goal for the latter to be of much immediate relevance. Though the WPA core curriculum and the article written by Professor Gelder show adequate awareness of the realities within developing countries, perhaps in their attempt to stand as an example to all branches of medicine and even an object lesson for medicine in its entirety [2] they have strayed some distance from these realities. For example, even nowadays, it is not usual in the majority of developing countries for medical students to receive post-graduate instructions before they become general practitioners or primary care doctors. From the perspective of these countries, the supplementary module containing additional material for management of psychiatric morbidity in primary care is as relevant as the core curriculum itself £ Paucity of psychiatry services in most developing countries makes it necessary for primary health care doctors to not only manage a majority of psychiatric problems themselves but also to train and supervise primary health workers in this task [2,3). Management of psychiatric emergencies is also an essential part of this set-up. These find no mention in the core curriculum itself or in Gelder's article and are significant omissions from the perspective of developing countries.

The role of other medical teachers and medical school administration is discussed in the article, but what is conspicuous by its absence is the role of behavioural and social scientists. Experienced teachers belonging to these disciplines can impart a significant part of the knowledge (e.g. psychiatric symptoms, psychosocial issues) and skills (e.g. interviewing, information giving, counseling) required by the medical students. This is even more relevant for developing countries, where availability of psychiatrists in teaching jobs is extremely limited and is actually decreasing, partly because of much better financial returns in private practice.

Use of recording technology (e.g. audio and video tapes) and of computer assisted teaching material (e.g. problem based interactive learning packages) as well as use of e-mail and internet can also play a major role in psychiatry teaching everywhere, but especially in developing countries. Video players and computers are already available and indeed affordable in most of these countries since the cost of hardware is decreasing every year. Use of such technologies is extremely cost-effective and these can replace in part and also supplement conventional methods such as classroom and bedside teaching. Although the point made by Gelder about these aids to be made locally is valid, national or regional level teaching centres can take the lead and develop these materials on a regular basis for their country or region. The relevant

question now is not whether developing countries can afford to use these educational technologies but whether they can afford not to use them.

Overall, the article by Gelder and the core curriculum document contain much that is good and useful. They are valuable contributions that enunciate common objectives and consensus statements and provide a clear direction in this important but until now neglected area. What remains to be done is to develop practical strategies for translating these into action plans to standardise and improve psychiatric teaching for medical students in widely different settings across the world. Perhaps taking a cue from the World Psychiatric Association, the national associations will undertake this urgent task in their respective countries.

References

1. Isaac MK Chandrasekar CR Murthy RS Mental Health Care by P""~' Care Doctors: 8angalore. NIMHANS. 1994.
2. Walton H) Foreword WPA Core Curriculum in Psychiatry for Medical Students; World Psychiatric Association, 1998.
3. Ramana R Saxena S. India: quality and access are the priorities. In: Mental Health Services in the Global Village Appleby L and Araya R (editors). La~don: Gaskell: The Royal College of Psychiatrists, 1991; 3-13.

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Alfred M Freedman

One must admire the succinct but comprehensive article of Professor Gelder that not only discusses a core curriculum but gives us a picture of the present status of psychiatric education of medical students including some recommendations for improvement of such programs.

Professor Gelder wisely points out that the curriculum must be configured to the future needs of the medical student whilst taking into consideration the postgraduate training in psychiatry that can be expected. Each country and region requires careful planning of appropriate teaching in psychiatry. For example, in the USA in recent years only 3~t% of medical school graduates entered psychiatric training. There, the curriculum must be oriented to the 95% or more of students who will not become psychiatrists. Unfortunately, too often in the past, and even presently, programs have been more suitable for an aspiring psychiatrist than a future primary physician or nonpsychiatric specialist. This, regrettably, has a chilling effect upon the bulk of the students who see no relevance of the program to their future responsibilities in medicine and contributes to a negative outlook on psychiatry in general.

If one could be assured of postgraduate training in psychiatry, particularly for primary physicians, it would permit a proper focus for the medical student program. Observations in the USA of a number of programs for family (general) physicians indicate that too often psychiatric training is minimized or squeezed to make room for `more important' subjects such as obstetrics and gynecology or general surgery.

Professor Gelder rightly emphasizes that `medical students value clinical skills'. In all stages of psychiatric education the individuals doing the teaching are of paramount importance and they should be capable of emphasizing the relevance of material presented to clinical practice in all areas of medicine. Behavioral science is generally caught in the first 2 years of the 4-year medical curriculum in the USA. Too often the program is dominated by experimental psychologists and anthropologists. Participation of senior clinicians is vital to show how the findings of anthropologists arc relevant to the day-to-day work in the psychiatric clinic. Likewise medical student teaching is frequently turned over to the most junior members of the department and senior psychiatrists are rarely or never seen. This deprives students not only of the richness derived from clinical experience but also the opportunity to perceive the teacher as a role model.

Medical student education must have the highest priority in the department of psychiatry accompanied by the vigorous support of the Chairman in order to achieve success. Teaching of skills and knowledge must be in the hands of enthusiastic faculty members with a commitment to and high regard of psychiatry. It would be well if they could bring fresh, innovative and creative approaches to their teaching. Faculty members

should view psychiatry as being intimately involved in all of medicine or in the words of John Nemiah `the inexhaustible science.' This can best be achieved by adherence to a biopsychosocial model and avoidance of imbalance and reductionism. Reductionism may be social, psychological or biological. None of these concepts should have a controlling influence on the curriculum.

Too frequently in medical schools worldwide, psychiatry has been subordinated to other specialties and denied facilities and adequate representation in the curriculum. For many this is a constant struggle that must be pursued. As Professor Gelder points out, the increased recognition of the high incidence of mental illness that is rapidly escalating compels attention to mental health in developing as well as developed countries. This requires sensitive programming appropriate for the culture and socioeconomic scaws of various countries. Similarly, special attention must be paid to the increasing minority populations made up of legal and illegal immigrants in all countries in the west. A sign of the improved status of psychiatrists in the medical schools of the USA is the fact that fourteen deans of medical schools are psychiatrists, a very recent development.

Not al) of the critical issues of psychiatric education are confined to the medical school. Decisions made outside the campus might be decisive. Thus, governmental support that subsidizes other specialties but not psychiatry can have ruinous effects not only on programs but in the recruitment of psychiatrists since it will lessen the regard students have for psychiatry. Similarly, reimbursement races that discriminate unfairly against psychiatry will discourage some students from a career in psychiatry and engender a negative attitude for all towards psychiatry. Finally, a good deal depends on the ethos of the times. Psychiatry thrives on an ambience of caring and concern for the individual. In times of greed and total preoccupation with technological achievement, regard for psychiatry will suffer. This state is not universal and there are encouraging indications that many attitudes to the sick are changing. This can only benefit psychiatry.

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Driss Moussaoui

Michael Gclder's paper is a remarkable one. This is no surprise coming from an outstanding teacher. However, it seems to me that teaching psychiatry to undergraduates is not only a matter of technique. It has something to do with the personality of the teachers, as well as with their communication skills and capacity to mobilize enthusiasm.

Teaching psychiatry is by no means an easy cask. Medical students start their rotation with a mixed feeling of curiosity towards the unknown, and anxiety when they face mental patients with all the stigma attached to them and to psychiatry. Curiosity is often a secret fascination and, through the patients, many students project their own difficulties and problems. The challenge is to transform this candid and sometime unhealthy fascination into the true one: to know more about the central nervous system and human behaviour, in order to help those in need of it.

Curiosity is mixed with anxiety. A number of students express clearly, if they are given the opportunity to do so, their concern about their own mental health during their psychiatric teaching. Some fear to be `contaminated' and become mentally ill; others fear to be physically assaulted. It is therefore essential not only to give faces and information about mental disorders and psychiatry, but also to accompany the students in the process of becoming acquainted with the anxiogenic mystery of mental disorders. This is quite similar to a psychotherapy which is conducted both on a group level, and an individual one for those who show more anxiety or resistance than others towards this teaching. This is why tutoring is so important, because proximity helps not only from a technical point of view but also from an emotional one. The best people to do such tutoring are the residents, if they are given the right backing to do this work.

The end of a rotation is felt by some medical students as a relief, and by many as an important part of their training; they have learned more about another side of medicine behavioral sciences and psychiatry. But as

time goes by, the fascination disappears, and what remains are a few images and anecdotes. Interest decreases and old stigmatizing ideas and behaviors come back to the front line. The fascination of the beginning is replaced one year after the teaching by an even more dangerous attitude: indifference. That is why, psychiatry teaching should be conducted throughout the life of medical professionals. Like vaccination needs to refresh the immunological memory in order to continue being efficacious, continuing education in psychiatry is as necessary to the doctor as its primary contact. Not only should this be made compulsory by law, but it should be given high priority from every aspect.

Destigmatising psychiatry, mental patients and mental disorders needs a big effort from the mental health profession in order to fight the fears appended to this field. The social marketing in other medical specialties (like family planning) has been felt necessary. The key of success is a mixture of good information and a seduction aimed at the targeted population.

If medical students feel that psychiatry is as important as ocher specialties, their teaching has achieved its main aim. It is during their daily practice as doctors that they should remember how mental disorders are frequent in general practitioners consulting patients as well as in those of nonpsychiatric specialists, and that they are highly treatable. Then the natural continuation of the undergraduate education should start, not only with up-to-date science, but also with a lot of heart and conviction!

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Rodolfo Fahrer

Since Alma-Ata, experience tells us there are specific arcas where 'health for all' in the year 2000 is still a utopia. Psychiatry is one of chem. If we are to be successful in our teaching role to achieve changes, we must first modify ways of thinking and teaching. Psychiatry emphasizes the unity of body and mind; however, we must be realistic and admit that not all faculties of the school of medicine act and think with biopsychosocial criteria.

The doctor-patient relationship is a moral contract that we as doctors make with patients who come to us for alleviation of their pain and suffering. As teachers we should ask ourselves: what is our purpose, our duty, our responsibility? Why did we actually choose to become doctors and then psychiatrists? What should we expect to give and to receive? An integrated perspective on prevention, care of the sick, and rehabilitation is a priority. Our chinking and training must be modified if we want our educational role in promoting changes to be successful.

The biopsychosocial model means not only a theoretical approach to the etiology of illness, not only the ability to diagnose and treat psychosomatic problems, but it represents and it means a `way of being' for the professional with his patient, the patient's family and his colleagues. This approach implies having specific attributes which can be caught and learned. It is a technique which is not just a medicine gift naturally inherited.

In order to achieve this goal, schools of medicine should have properly trained teaching staff qualified and convinced about their value. It is the psychiatrist's job to educate both the medical teachers and students integrated in a setting such as the general or university hospital, which will allow the daily sharing of the responsibility of the patient's care. Given the fact that psychiatry should have a major part in the medical curriculum (as its skills are useful to all medical practitioners and psychiatric problems are very common among patients who visit doctors working in all branches of medicine), our priority is to achieve effective teaching so that future doctors will be prepared to confront successfully the mental health needs of people and the community worldwide.

If training the physician in psychiatric skills aims at achieving an integrated professional, with a sound medical identity as well as with the appropriate attitudes, skills and knowledge, within a biopsychosocial

conception, the teaching of psychiatry should be included in the medical curriculum as a whole. It is not enough to teach psychiatry to students during 4, 6 or 8 weeks.

Perhaps the teaching of psychiatry might be best achieved gathering students in homogeneous closed groups (in the sense that they always follow the studies of different subjects together) according to good previous school performance and important intellectual interests together with a high reading and comprehension capacity. Thus composed, the group spirit is very strong and constitutes an element which, with the proper guidance, can facilitate the entire formation process, affording the opportunity to generate questions and inquiries encouraging knowledge. The teaching method, combining theory and practice, is aided by a student's actual work in the hospital since the first day of their career, and this allows for theoretic classes with practical demonstrations related with each subject and with active student participation.

Faculty is distributed in such a way that the same professor of psychiatry is in charge of teaching psychology and psychiatry every year as the course advances. This makes up for better continuity in the relationship between professor and students, from the educational as well as from the personal point of view. Professors should have a high level of academic and pedagogic formation, as well as a mature personality (personal integrity). Students' difficulties are related with time and effort required by this programme as it demands full time commitment throughout the entire career:

We, have been working with this methodology [`Tutorial Curricular Experience, (Plan B)'] at the School of Medicine University of Buenos Aires, since 1993 and the outcome is good. At postgraduate level, the concept of working together' in clinical or research programs ; with different departments of the teaching hospital has proved successful; in general, primary care physicians are better trained; entire motivated and able to ''resolve many of the problems previously referred to the psychiatrist. Since the creation of the Chair of Medical Psychology in 1967 in our Department of Mental Health, we have been working in the primary care field, teaching and training primary health physicians and allied professionals. Since 1984, we have developed specific teaching programmes under the modality of `working together' for which the outcome is also very good.

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Toma Tomov

The under-privileged position of psychiatry in the medical school curriculum reflects the degree to which the community at large disavows emotional problems of individuals. Cultures differ in this respect and such must be the case with medical schools, although no study showing such a relationship is known to me. (I doubt if such a study is actually possible or feasible, because of the difficulties in interpreting cultural variables.)

The practice of organising ill health in nosological units and disciplines expedites teaching and learning enormously. The advantages of this approach are so numerous that all willingly turn a blind eye to any negative sides. Psychiatrists on school boards, who care for students and patients alike, can afford to be vocal about this only to a certain point. Overdoing it renders school boards not more, but less ready to admit the limitations of this system. Introducing ICD-10, chapter V as part of the medical curriculum in psychiatry is a rare opportunity to point to the importance and advantages, which case-formulations have as compared with the limited value of diagnostic labels in at least 30% of cases in general practice. Placing ill health in context is very inspiring to students.

Medical schools are conservative by tradition and barely react to political processes in society. But at times of major transitions, such as those currently under way in Eastern Europe, even medical schools recognise openly that they need to change. Violence causing ill health, institutional and domestic violence in particular, acquires such overwhelming importance in my part of the world, that pressure on medical schools to respond cannot be resisted. Fortunately, post-traumatic stress disorder has been introduced for common clinical use just in time for psychiatry to be somewhat prepared to meet the expectations addressed to the

medical profession and to live up to its high social mission. Notions such as trauma and victimisation are totally out of tune with the sexist and racist culture of most present day communities, and their introduction in the medical curriculum, appropriately showing their cultural relevance, can have surprising implications.

One such implication is the conflict in the professional identity of the doctor. The inappropriateness of the arrogant, triumphalistic attitude, which the medical student soaks in from classes in the medical and surgical wards, becomes exposed when they are confronted with a rape victim at the crisis center whom they interview.

Teaching which emphasises practical skills and personal experience, and which present day courses in medicine aspire to do, has to adopt very different methods for conveying knowledge and examining students. Context is once again crucial, this time the individual make-up of the student as the context with which medical training interacts to produce a doctor. To evaluate this is such a difficult job that faculty councils tend to gloss over the issue. Psychiatrists once again appear to be at odds with everybody else. They insist on tutoring as a method of particularly powerful formative capacity, or should do so, if they themselves are properly trained to be at ease with words describing feelings. The usual argument of school boards for turning down such proposals is that this is too time consuming and costly. A way out of the situation is to accept that indeed only those of the students who are willing can benefit from this and that the right to choose should be provided to all.

To summarise, a core curriculum in psychiatry of universal acceptance is a dream for all of leadership calling in the field. And yet the world is so varied and communities so persistently surprise us with the norms and practices they adopt without warning that designers of curricula need to be alert all of the time.

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Harold I Eist

Professor Gelder addresses a topic of critical importance to the vast uncared for populations of individuals worldwide, suffering from mental illnesses. I agree with him that a core curriculum for general or family practitioners should include anxiety spectrum and depressive spectrum disorders, but I would also include obsessive-compulsive disorder which is more common than previously thought. At some point too, possibly during pediatric rotations, the more common childhood emotional disorders should be taught. I would also include, in agreement with him, delirium and dementia, but I would exclude substance use disorders from the core curriculum. These cases are almost invariably complex, are accompanied by significant comorbidity, which must also be treated if the addiction is to be brought under control, and they require a great deal of time and patience. Further, for those general practitioners that have attitude problems with the mentally ill, they will prove more of an issue with addicts who are often responded to moralistically by our nonpsychiatric medical colleagues.

Provision should be made for sufficient curriculum time to accomplish this essential training. This will require the cooperation of deans of medical schools and the chairs of all departments, with the additional strong support of consultation-liaison psychiatry, so important to both teaching the connections between the psyche and soma and assuring truly comprehensive patient care.

Professor Gelder correctly stresses the necessity of teaching information giving skills. This insufficiently addressed area is responsible for many treatment failures, excess hospital days, and even increased mortality. It has clearly played a part in the development of antibiotic resistant strains of bacteria and unnecessary relapses. Since a high percentage of the world population is functionally illiterate, and many illiterate or only partially literate people are ashamed of this problem and have become good at hiding it, information giving skills become even more important if treatments are to be helpful. However, information giving is time consuming, requires tact, and the capacity to engage patients in such a way as to determine that they fully understand the treatment process, the important role they play in it, and the risks to them if

they do not follow through. Unfortunately, many if not most genera1 practitioners lack the temperament and time to provide adequate psychiatric care.

It is clear that all physicians will be better doctors if they learn basic psychiatry, which should be as much a part of their core curriculum as internal medicine or surgery. However, this will not make up for the enormous worldwide shortage of psychiatrists and child psychiatrists. The solution to this problem is in training more psychiatrists.

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Quentin Rae-Grant

Psychiatric illnesses are the most common in the field of medicine, the most frequently undiagnosed and the most expensive both in direct and indirect costs (such as poor performance at work or frequent absenteeism). They are among the highest causes of death, particularly in adolescents and young adults. Yet the support for people who suffer from these illnesses is low in service, funding, and in research.

There will never be enough fully trained psychiatrists to care for these individuals. Even in developed countries, the availability of trained psychiatrists is grossly distorted, with most clustering round the teaching and university centres, leaving many areas `underserviced'. The care will therefore devolve to primary care givers, such as family practitioners, alone or in collaboration with specially trained nurses and other personnel.

The pressing question is as to the best way for doctors to have appropriate training in medical school. There are a number of factors that make this increasingly difficult to achieve. Knowledge in medicine is advancing at a lightning pace and the same is true of psychiatry. The competition for time in the curriculum becomes ever more pressing, particularly for an area which is still seen as less prestigious than many others.

Psychiatry itself is undergoing major changes. More has become known of how the brain functions in the last 10 years than in the previous 2000, with the main emphasis on the biological, neurotransmitter and psychopharmacological areas. This has led to a diminution in attention cowards the person, and more towards diagnosis and prescription.

What are the essential ingredients of psychiatry's training contributions in medical school? First one would wish to emphasise ability and interest in the person who has the illness as this may influence both diagnosis and treatment. As this is becoming less a part of daily practice it may have contributed to the diminished regard in which doctors are held and promoted interest in alternative approaches. The ability to give information even when it is painful and negative, in a sympathetic, supportive but unambiguous way is equally important.

The change in practice of psychiatry leads to less opportunity to demonstrate the techniques and to discuss them. Academic centres are giving more emphasis to research and the funding for this and less recognition to teaching. Good researchers can be, but often may not be, either interested or comfortable with teaching, particularly at the undergraduate level. Problem-based learning standardises the approach and also requires a greater commitment of time and interest.

If much of the detection and treatment is to be done by the general practitioner, perhaps it is preferable, particularly in later training, to have this take place in a community rather than an academic centre, namely in a situation more similar to where the trainee is likely to practice.

Finally, if there is to be better care for those with mental health problems, including addictions alone or often combined with psychiatric issues, the still dominating issues of fear, prejudice and stigma must be addressed. We are only now beginning to institute programs for physicians with these difficulties, admitting that they are a major problem which is far too often hidden and ignored. We are being helped by educational

campaigns, and as more prominent people in society come forward to discuss the problems that psychiatric illnesses present for the individual and the family. But the effort must continue at all levels, not least of which in medical school and in medical education.

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Juan E. Mezzich

The article by Michael Gelder is to be commended for the wisdom of its scope. Its balanced consideration of knowledge, skills and attitudes in the educational process are particularly stimulating, and the pointed attention he recommends to the concerns and fears that medical students bring with themselves, as well as to the value of involving the students with their patients' histories and families. The latter may be helpful in dealing with stigmatization of mental patients, a phenomenon prevalent not only in the community at large, but among health professionals (including psychiatrists) as well.

A critical level of discourse that needs to be recognized when discussing psychiatric education for medical students is the ethical one. To this effect, it may be useful to consider a dual responsibility for the medical and psychiatric educator: technical competence and human responsibility. In the clinical care field, these responsibilities are referred to by the historian and philosopher of medicine Laín Entralgo [lJ in terms of two fundamental roles for the clinician: *ego sapiens* and *ego adjuvans.*

Technical competence on the part of the psychiatric educator should principally involve two aspects:

1. Clinical competence. This refers to proficiency in the knowledge, skills and attitudes required to carry out effectively the duties of a psychiatrist, i.e. to diagnose and treat mental disorders and to promote higher levels of health and quality of life. Of particular relevance to ethical concerns here is attending to the etymological roots of health and healing, which can be traced back to the Sanskrit `hal', meaning wholeness (2). Competence in dealing with wholeness is pertinent to the entire clinical care process: (a) understanding psychiatric disorders within the context of general medical disorders and social problems, as well as recognizing the critical relevance of emotional and behavioral factors to non-psychiatric disease, (b) emphasising, under diagnostic interviewing, the need to listen well and to consider the cultural framework of illness, health and the patient’s life, a point compelling in today's multicultural societies, and (c) learning and practicing how to work collegially and effectively with a multidisciplinary health care team.
2. Pedagogical competence. The psychiatric educator must also be competence in teaching techniques and capacities. Illustratively, this requires certain skills: (a) the ability to present motivating and informative lectures, (b) proficiency in conducting feedback-rich teaching activities such as small group discussions and individual learning modules, (c) effectiveness in using actual clinical settings for teaching purposes, and (d) adequacy in serving as a role model for students.

The human responsibility of the psychiatric educator may encompass several elements:

1. Promotion of the human development of the student. This may involve facilitating the students' self expression, dealing with their fears and insecurities, and attending to their particular needs and goals.
2. Facilitating the fulfillment of the responsibilities of the future health professionals in their likely work settings, paying attention to local resources and culture.
3. To respect the human dignity of the student, who is not only a prospective operator or social resource, but also a human being with a unique life history, personal qualities, and, particular aspirations. This respect is a reflection of respect for the human dignity of the patient, which is at the core of the human responsibility of the clinician.

Attending to the ethical perspectives of psychiatric education is fully in line with the mission and work of the World Psychiatric Association. It is pertinent to its constitutional commitments, the ongoing development of procedural guidelines, and the conduction of its institutional activities.

References

1. Laín Entralgo P. El diagnóstico médico. Barcelona: Salvat; 1982. El diagnóstico médico. Barcelona: Salvat; 1982.
2. Mezzich JE. Ethics and comprehensive psychiatric diagnosis. Psychopathology 1998 (in press) (Special Issue).

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