THE ROYAL COLLEGE OF GENERAL PRACTITIONERS

Report on

EDUCATION IN PSYCHOLOGY AND PSYCHIATRY

CONTENTS

RECOMMENDATIONS

Undergraduate

1. Human relationships are a proper subject for scientific study by all doctors. Undergraduates should be introduced to them at the earliest stages of the curriculum. The integration of experienced general practitioners into teaching units would serve this purpose.

Preclinical

2. Psychology should be taught in all medical schools. More time should be given to it than the present average, which is well below the recommendations of the World Health Organization.[9]

3. Sociology should be taught in all schools.

4. The study of behavioural sciences should be considered as important as that of anatomy and physiology.

Clinical

5. Psychiatry should be regarded as a major subject, comparable to medicine and surgery—and given an appropriate share of the curriculum. There are still wide variations between different schools in the emphasis given to the subject.

6. The emphasis in teaching should be better related to the prevalence of problems in general medicine. Normal psychology, psychosomatic aspects of medicine and problems of neurosis should have greater attention than at present.

7. The student should be required to make a limited psychological and social assessment on every patient he clerks throughout the clinical course. He should have the opportunity to interview patients by himself in private.

8. In the teaching of psychiatry and human relationships, more use should be made of patients in the community and of potential teachers from other specialties—including that of family medicine. All students might be attached to a general-practitioner tutor during their clinical studies. We believe that increased teaching about health and disease

in the natural environment of the community outside hospital would best be achieved by demonstrating these patients in general-practice teaching units.

9. Group support should be available for students to discuss their own problems and attitudes in relation to patients. The skills of medical and psychiatric social workers as well as those of physicians could be used in this context.

10. All schools should adopt a compulsory examination question on human relations or psychiatry.

Postgraduate

11. A national programme for the special vocational training of general practitioners is needed urgently. Human relationships and psychiatry should be a major subject in each part of this programme.

12. No doctor should be encouraged to enter general practice if he has any reservations about his aptitude for human relationships and his interest in people.

A three month house appointment in a psychiatric department or weekly attendance as clinical assistant in a psychiatric outpatients clinic for an academic year

and two years experience in training practices,

and attendance at an organized introductory course on general practice of not less than thirty half-day sessions;*

or attendance at a course of approved seminars like those at the Tavistock Centre, London,[20]

or a formal course in psychiatry of not less than two weeks.

13. The minimum future requirements for postgraduate vocational training in human relationships and psychiatry should be:

14. New types of senior house appointment in the psychiatric department of general hospitals and in psychiatric hospitals are required for the training of men and women intending to become general practitioners.

15. Interest and training in human relationships and psychiatry should count heavily in the selection of general-practitioner teachers. A registrar who has missed this type of help in his first training practice should be guided to find it in his second.

*Existing extended courses are of this length and devote about a third of this time to the psychological and social aspects of general practice.

THE WORKING PARTY

H. N. LEVITT, *O.B.E.* (London) (Chairman)
J. P. HORDER (London) (Hon. Secretary)
M. J. F. COURTENAY (London) (Hon. Asst. Secretary)
P. HOPKINS (London)
A. U. MACKINNON (Leeds)
H. R. PLAYFAIR (Plymouth)
R. A. B. RORIE (Dundee)
C. A. H. WATTS (Leicestershire)
DOROTHY WEST (Plymouth)

PROFESSOR SIR DENIS HILL kindly agreed to act as adviser. He was later joined by PROFESSOR J. M. HINTON.

The working party gratefully acknowledges the help of many members of the College Council and also of DR R. H. GOSLING.

I

INTRODUCTION

IN JULY 1965, a meeting was arranged by the director of the British Postgraduate Medical Federation, to consider the needs of general practitioners who wished for further education in psychiatry. The College of General Practitioners was invited to take part. Increased provision for courses on this subject was not taking place according to any organized plan; there was indeed a falling off of applicants for existing courses. This was giving rise to concern.

The Council of the College responded by appointing a working party. It was given the following terms of reference:

1. To study the needs of the general practitioner for education in psychology and psychiatry, both before and after qualification.
2. To make recommendations on how these needs are to be met.
3. To report to Council within one year.

The working party met five times during the year. A great deal of work was done by correspondence.

At the first meeting definitions of psychology and psychiatry had to be found. The role of the general practitioner in this field was outlined and the types of problem which frequently came his way listed.

Stedman's Medical Dictionary and the *British Medical Dictionary* define psychology as the branch of science which deals with the mind and mental processes. Psychiatry is defined as the recognition and treatment of diseases of the mind in the first dictionary, and in the second as the study of diseases and disorders of the mind. The working party agreed that while both formal psychology and psychiatry play a part in general practice, they are relatively unimportant compared with the basic problems of everyday personal and family medicine.

These problems, which arise frequently in the working day of the family doctor, include the crises of birth and death, emotional reactions to illnesses and injuries of all types, lesser life-crises like puberty and climacteric, the stresses of family life, problems of employment and the special difficulties of such vulnerable groups as unmarried mothers, one-parent families, the lonely and the elderly. He must sometimes deal with more than one disturbed or unhappy

person in the same family. Although the psychiatrist will at times face some or all of these problems, they form a very important part of general practice. They do not find a place in any classification of psychiatric disorders.

Formal psychiatry is also important in general practice. In this setting it is dominated by anxiety neuroses, depressive states and psychosomatic disorders. Psychoses other than depressive states are less common. Alcoholism may be increasing. Subnormality is comparatively rare. Even senile psychoses are less common than in psychiatric hospital practice.

If these are the sort of problems with which the general practitioner is called upon to deal, there is another series of problems in his own attitudes to them. If he is to succeed in his work, he will need both to develop and show interest in these disorders and difficulties. He will need to be tolerant and uncritical, and capable of judging when it is right to be passive, leaving decision to the patient, and when to be firm because the doctor's own decision is essential. He will need to live with uncertainty in this largely uncharted field, to have limited aims and to face feelings of impotence when a patient cannot be helped. He will need to be neutral when dealing with emotional crises involving several members of a family. He will need to recognize over-enthusiasm or anger in himself and control them so that they do not interfere with his judgment or management.

His main role in this part of medicine is the assessment of the problems which his patients present to him. He is also concerned with treatment and referral, with prevention of mental disorders and with the promotion of mental health. Theoretically these functions should be listed in the reverse order, but the order here given is a realistic statement of priorities in the present condition of general practice and psychiatry.

Assessment

Early assessment is the responsibility of the general practitioner in this as in other parts of medicine. Psychological illness frequently presents with physical symptoms. The danger is either that, no evidence of physical disease having been found, the patient is diagnosed as having a 'functional disorder' and 'reassured'; or that a series of investigations and treatment for physical disease is embarked upon and the patient's illness crystallized around physical organs. The assessment made by the general practitioner should properly be in depth. It should take account of questions such as why the patient has come on a particular day or at the end of surgery or why he has an unusual attitude such as inordinate anxiety over a trivial problem or why he brings a particular request for a tonic, an x-ray or a check-up. To make a proper assessment it may be

necessary to give him or her time to talk about worries and fears. The practitioner's existing knowledge of the patient and the family often help him in reaching an accurate diagnosis. It is just as important not to miss or mis-diagnose the early signs of emotional disturbance and to be able to recognize psychiatric illness in the early stages as it is not to miss an early organic illness.

Treatment

The bulk of psychological problems that are brought to general practitioners do not require referral to psychiatrists. In fact only about one in ten of them are referred.[1] [2] [3]. Assessment, when made in depth, and allowing the patient to talk, is frequently therapeutic. Simple psychotherapy—listening to the patient, explaining symptoms and interpreting behaviour—is within the scope of most general practitioners providing their training has stirred their interest and showed them how to start and when to stop. Psychotropic drugs are used by all general practitioners and are powerful weapons. Training and supervised experience is needed to teach their proper use, dangers and limitations.

Referral

If the patient is severely disturbed, if a second opinion is needed or if some special treatment is needed beyond the general practitioner's skill, referral will be necessary. Psychiatric referral needs careful and sympathetic preparation so that the patient neither loses confidence nor feels rejected. The general practitioner must interpret both to patient and family the nature of the trouble and the treatment required. He still retains ultimate responsibility for the patient's welfare.

After-care

It is particularly important if referral includes admission to hospital that the general practitioner should resume responsibility on discharge. The increased emphasis on community care of the mentally ill means greater involvement of the general practitioner in the after-care of many convalescent patients and some chronic invalids. He can fulfil his responsibilities more easily if he knows the psychiatrists, mental welfare officers, psychiatric social workers and after-care nurses personally. He may have to enlist the aid of many other agencies for particular cases, and here again, personal acquaintance with those who work in other parts of the social services is invaluable. He himself is at the focal point of communications between the patient, his family, the hospital and the community services.

Prevention

All schools of psychiatry emphasize the effects of faulty conditioning and adaptation in the early years of life. Such factors are

sometimes open to modification by an interested family doctor and he therefore has opportunities for primary prevention. Neurotic patterns of behaviour are passed through generations, from grandparent to parent and from parent to child. This transmission is not always due to genetic influence, but often to example and home environment. It is the duty of the family physician to break this cycle if and where he can. While family friction is not always avoidable, parents can be helped to solve their difficulties, thereby preventing permanent damage to the child (who is intuitively sensitive to home atmosphere). The neurotic parent can be helped not to work out his or her anxieties on a child. The physician himself must always be on guard against clumsy handling of organic illness and excessive emphasis on medical care which may produce a 'delicate' child. Misguided search for organic illness in the face of neurosis, while it may relieve the doctor's own anxiety, can do untold harm to a healthy life.

Marriage is perhaps the most emotional experience in a person's life; we are all aware that ignorance can cause unhappiness in marriage. Education must start with the courting couple. The prolonged engagement can be an obvious traumatic experience for both parties. So can a difficult honeymoon. These are difficulties which can be anticipated; opportunities can be given for the airing of ignorance and fear. Young people need not look beyond their family doctor for such help.

With the completion of the family further emotional crises have to be passed in finding satisfactory birth-control and in dealing with interpersonal friction within the family. When aged parents return to be cared for, old child-parent tensions are renewed and have to be mastered. Finally, illness and death, bringing morbid reactions of guilt and depression, can be foreseen and managed by previous discussion.

In the cycle of health, illness and treatment, prevention merges with early treatment at one point, at another with after-care. Thus the general practitioner also finds himself involved with secondary and tertiary prevention.[4]

Promotion of health

No line can be drawn between the prevention of mental disorder and the promotion of mental health, but it seems valuable to consider this positive activity as an additional role. Certainly, the general practitioner needs a concept of mental health and to know the characteristics of people who are healthy in mind. Attempts at these definitions can be found[5] [6] [7]; the fact that they would not secure universal agreement does not make them worthless. The general practitioner's best opportunities arise during his care of

pregnant women, particularly during their first pregnancy, with those about to marry and in well-baby and toddler clinics where the earliest relationships between mother and child are open to influence. Most of this work will take place during consultations for other purposes. A few general practitioners organize more formal health education by arranging discussions for special groups such as young parents. Their increasing involvement in well-baby clinics encourages this trend.

No one doubts that the general practitioner is well-placed and has innumerable opportunities to carry out these roles in this part of medicine. He usually knows the patient, his family and the background already. He knows a person's normal bearing and behaviour. He is accessible and therefore gets the best chance of making an early diagnosis. Many of the problems that are brought to him are neither difficult nor long-standing. If he needs specialist help, it is increasingly available. But these opportunities can only be used by the doctor who is alert to them, sees their significance and has enough interest and experience to know what to do. To ensure this, proper training, both before and after qualification, is a basic need.

II

EDUCATION

Important changes are taking place in medical education at the present time. Some of them particularly affect the general practitioner.

Whereas in the past one of the objects of the undergraduate curriculum was to turn out a safe general practitioner by the time of qualification, this is now thought neither desirable nor possible. The undergraduate period is gradually becoming a period of basic university education in medicine, fitting a man for any career in medicine, providing he has further training in his chosen branch. This means that special training for general practice *must* be available in the early postgraduate period. Logically, it should become obligatory. To fit this trend the present report considers education in psychology and psychiatry both before and after qualification. In considering this aspect of *undergraduate* education it has in mind that the curriculum must be common to all future doctors and it cannot make proposals which are suitable only for those who may

become general practitioners. For the *postgraduate* period it makes proposals only for the special training of this branch.

The other important trend is the increasing influence of the behavioural sciences, particularly psychology and sociology, on medical education as a whole in the last 25 years. This trend is welcomed by the working party since it can supply an important need in the educational background of generalists working mainly in the community. It has to compete with the pressure from the rapidly expanding biological sciences for its quota of the undergraduate curriculum and the working party hopes that its own report will give further impetus to the trend.

III

UNDERGRADUATE EDUCATION

The present position

(1) The working party sent a questionnaire in March 1966 to all medical schools in the United Kingdom and Eire (31 schools). Replies were received from professors of psychiatry or heads of psychiatric departments in all these schools except one, and the working party is most grateful for their help. The questionnaire and the results are published in Appendix II to this report. The replies confirm the working party's impression that there has been a great increase in undergraduate teaching of psychology and psychiatry in recent years. There are, however, great variations between different medical schools.

Preclinical teaching. Psychology is taught in 23 out of 30 schools, most of them giving between six and 30 hours teaching. One school, Aberdeen, gives 50 hours. The aspects most commonly taught are described as Experimental Psychology, Physiological Psychology, the Psychology of Human Development and Psychodynamics. Only six schools demonstrate patients and their problems at this stage.

Sociology is taught in six schools only, to a maximum of 20 hours.

Clinical teaching. Psychiatry is taught in all medical schools (except Cambridge which has no undergraduate clinical school). The total time varies from ten to 250 hours. Lectures are the teaching method most commonly used (all but two schools)—the total time usually devoted to them is 17–25 hours, but there are wide

variations. Demonstrations are used by 18 schools—most of them for about 15 hours, but by three for about 70 hours. Seminars (group discussions) are used in 25 schools, varying widely from three to 72 hours per school. All but one school provide students with experience in clerking for psychiatric patients (the one exception is about to introduce this); there are, however, variations in duration from six hours to three months.

All schools teach about subnormality but only half give any experience, theoretical or practical, in psychotherapy, which is of greater importance.

There is combined teaching with medical, surgical or other non-psychiatric firms in 15 schools, but throughout the three clinical years only at one school (Guy's, London).

Some sort of examination in psychiatry is available in 28 schools, but it appears to be compulsory in only seven.

Experience in general practice. This is obligatory in eight schools (Charing Cross, King's College, Oxford, Leeds, Newcastle, Sheffield, Aberdeen, Edinburgh). A further 15 schools have voluntary schemes. This information is included since the working party believes that general-practice attachment schemes are relevant to the teaching both of formal psychiatry and of the less defined aspects of human relationship with which this report is also concerned.

(2) *The working party's questionnaire to general practitioners in Leicestershire and Yorkshire* (Appendix I) throws a little light on the psychiatric education of doctors now in practice (qualifying in the period 1903–1961). Only half of them have been taught psychology and only 13 per cent of them sociology in the preclinical period.

All but 12 per cent had been taught psychiatry. Of the five main clinical subjects—general medicine, general surgery, obstetrics, paediatrics and psychiatry, they rated psychiatry lowest (fifth place) both in popularity and in the merit of the teaching they had received. When asked, however, their opinion about the needs of medical students today and in the future, they rated psychiatry third in the list (after general medicine and surgery). Evidently experience in general practice causes doctors to see greater importance and interest in psychiatry than they would see when they were themselves students.

(3) *Comparisons with other countries.* The World Health Organization Expert Committee on the Undergraduate Teaching of Psychiatry and Mental Health Promotion (1961) laid down certain minimal standards for the teaching of these subjects:

Psychology: 40 hours
Sociology: 20 hours
Psychiatry and mental health promotion—Formal teaching: 60 hours
Clinical clerkship: 1 month full-time

This report supports the view of the present working party:

'The status of psychiatry has begun to change. Besides being regarded as a fully-developed specialty, it is also considered a sort of leaven permeating medicine as a whole . . .

'In stating the aims of the undergraduate teaching of psychiatry and mental health promotion consideration must be given to the double role of these disciplines. The student must acquire a certain knowledge of them in so far as they are specialized approaches to the handling of strictly psychiatric problems. He must also absorb ideas and develop attitudes which are basic to his future role as a doctor'.

Undergraduate teaching of psychiatry in the U.S.A. and Canada

There is such a diversity of teaching practice that it is impossible to give a comprehensive summary.[8] It was found that the best examples were highspots in transatlantic medicine, in that the concept of family care with its emotional stresses and disguised psychiatric problems had been accepted into the curriculum. The junior student was introduced, at a very early stage, to the psychodynamics of the doctor-patient relationship. The dual role of the psychiatrist as specialist and sub-physician to all other specialites had produced a unique pattern. In almost all schools, in the words of the World Health Organization,[9] psychiatry receives a 'princely allocation of hours' in comparison with European practice. These figures do not even include the so-called 'hidden hours' in which the psychiatrist participates in the teaching of other specialties. The teaching is extended over all four years of the medical course and as much as 200 hours may be devoted to combined teaching programmes. An examination is compulsory in all the 24 schools investigated except Yale. The National Board Examinations contain compulsory questions on psychiatry. Psychology is included in the teaching of psychiatry. There is evidence of continual evolution in the teaching of undergraduate psychiatry. See also Trethowan[10].

Undergraduate teaching of psychiatry in the U.S.S.R.

According to the World Health Organization[9] there are 79 medical institutes in the U.S.S.R. (1961). The syllabus sets aside 200 hours for psychiatry and neuropathology together, about equal time being spent on each. Forty per cent of the time is given to lectures, sixty per cent to practical training. Of the patients studied by the students, two thirds have major psychoses (including epilepsy and senile psychoses), one third being 'minor' psychiatry, including psychopathies, neuroses and pathological development of the personality. There is, however, local variation according to the particular research interests of the school. There is a recent move to cater for the needs of general practitioners, though it is emphasized that this does not involve lowering standards. The connections between psychiatry and philosophy and between psychiatry and sociology are also mentioned, but these apparently have political implications.

Future needs

(1) *The aims*

The chief aim is to make all students aware of what Henderson[11] called the 'other half of medicine', and as far as the future general practitioner is concerned, to lay the foundation of what he needs to know of psychology and psychiatry. This mainly involves the gradual inculcation of attitudes which will allow the future doctor to be able to apply all his medical knowledge with the greatest

possible effect. To quote Lord Cohen:[12]

". . . The greatest danger confronting medicine in this scientific era is that we shall overlook that men, whether patients or doctors, are sentient, social beings, who need sympathy, kindness and encouragement. The doctor will ultimately be judged not by the potent weapons which he has designed for the recognition and control of disease, but by the human understanding and wisdom which he brings to their use . . ."

At present the medical student is taught an 'objective view' of disease, which obscures the essential unity of the human being. This attitude is strengthened by the fact that it is uncomfortable to find the patients display similar mental and emotional processes to the student himself, and that they raise the question so aptly put by Roberts[13] into the student's mouth, "Why is this man a patient and not me?" It should be the purpose of any training programme to bring the resources of the behavioural sciences to the aid of the student to increase his human understanding and give him the opportunity to become a wiser doctor.

(2) *Content and limits*

Preclinical. At the moment, while the ratio of normal : psychosomatic : neurotic : psychotic patients is on a sharply descending scale 500 : 100 : 50 : 1, the emphasis in their teaching is often in exactly inverse proportion. In fact the medical student may qualify knowing something about psychotics and nothing about normal psychology at all. While deviations from the normal must clearly be dealt with at the clinical stage, there is an excellent opportunity at the preclinical stage to give the student a grounding in normal psychology and sociology.

As Roberts[13] says:

'We can think of this doctor having a respect for and an acquaintance with the general conceptual framework of the behavioural sciences. The early part of the course might concentrate on the various psychological and sociological methods by which human beings can be studied. These methods could be used to illustrate the psychological development of the individual, psychological processes at various stages of development, the way in which the family unit develops and its importance for the individual stages of development, and the way in which various observations of animal behaviour aid in our understanding of human beings. The raw material for most of this study is to be found in the student, his colleagues, his family and the local community. These ideas lead on to a consideration of statistical and sociological aspects of medicine. By studying himself and others in this way he will mature and develop a broadly-based view of man and society, and be able to see that the behavioural sciences are of equal standing with the other branches of his studies as regards methods, relevance and content'.

There is, however, a danger to be avoided. Preference may be given to the teaching of academic and experimental psychology. 'Universities may turn even the study of human behaviour into something in which man as a statistic is recognized, but from which man as a personality is excluded . . .'[14] To avoid this, the dynamic

aspects of the development of the human personality and of man's emotional experience of living must be stressed, as suggested by H. H. Wolff.[15]

The time taken to teach these subjects would be bound to curtail the amount of time given to other basic sciences. There is already a move to reduce the amount of anatomy teaching at the preclinical level, and this would achieve a better balance at this stage of the course. After all, if a student is faced with 500 hours of anatomy and five hours of psychology he must be forgiven if he draws the conclusion that his mentors consider anatomy to be a hundred times more important that psychology. For the general practitioner sitting in his consulting room the falsity of such a proposition needs no elaboration.

Clinical. When it comes to the clinical stage, the problem becomes more difficult because, apart from the requirements of learning in the field of specialist psychiatry, the student also requires to know about what in North America is known as 'non-specialist psychiatry'; this the members of the working party found difficulty in defining, although it was clear that they had an understanding of what it is. The best way of describing it is perhaps by calling it the science of human relations, for in this way it can be seen to grow naturally out the preclinical teaching of the behavioural sciences.

It must pay particular attention to the personal dynamic relationship between the doctor and his patient, and must include a study of interview techniques and methods of communication between individuals. An awareness of the family and community settings must also be brought in at this stage, because the dynamic interplay between members of the family and between the family and society may have far reaching effects on the individual. In this way all doctors would have some competence in dealing with the emotional invalid, rather than declare, as many still do, that they are completely at sea when faced with such problems.

The student's studies of psychological processes and human development would continue during the clinical phase. He would be able to distinguish between normal and abnormal psychological reactions associated with disease and to make psychological assessments of all his patients at all stages of his training. His experience in this approach must not be confined to the hospital setting, but he must be encouraged to study the situation in general practice (especially in the home), as well as in child-guidance clinics, special schools and in public health clinics. He needs to be shown how a variety of men, women and children behave in sickness and in health.

All this will contrast with the teaching of specialist psychiatry

because this is often presented in terms of syndromes, the aetiology of most of which appears obscure. The fact that general paralysis of the insane is a late manifestation of treponemal infection, that schizophrenia appears to have a genetic pre-disposition, that a lack or excess of thyroid may give rise to psychological symptoms, that head injuries may alter the personality, seem to support the thesis that psychiatric illness can be evaluated in the same terms as so-called organic illness. Yet the evidence that all psychiatric disturbance is based on such mechanisms is slender. Every doctor knows that he does not have to be ill to be angry or afraid, and so the distinction between pathological aggression and normal anger, or between pathological anxiety and reasonable fear is often of more practical importance. Equally important is the understanding of those psychosomatic aspects of illness which illustrate clearly the interplay between the emotional and bodily processes.

The working party's main intention is to advocate that the student's time should not all be given to specialist-psychiatry, but spread over a wider field, and that studies of the environment outside the hospital should not be forgotten.

(3) *Methods and teachers*

In the preclinical phase the incorporation of teaching in psychology and sociology might be most readily accommodated within the concept of a degree in Human Biology.[16] In this way the physical, mental and social functions might be studied simultaneously and pave the way to the medical student thinking of his patient as a whole, in a scientific way. Much lip service is paid to the concept of treating the whole man, but this is usually considered to be a combination of scientific physical medicine with attitudes which are only accidentally connected with the medical curriculum, if at all.

'Unless a student can see someone practising whole medicine and carrying within him the tensions that that entails, he will not be prepared to allow himself to use his own intuitions, sensitivity and knowledge. In turning a man into a doctor you have to show him a way of keeping his mind functioning when confronted with the most terrible scenes of blood, pain and death. This is done fairly successfully in our medical schools by dehumanizing the patient and splitting the subject up into parts or systems. If these parts and systems are to be allowed to come together again and to constitute a whole suffering person, then the student will need to be convinced that the pain is bearable, and this I think is best done at the student stage, through apprenticeship and identification with a master.' (R. H. Gosling, personal communication).

In the clinical phase psychiatry should be promoted to the status of a major subject equal to medicine or surgery and given an appropriate share of the curriculum.

The increased time should be used in studying the more typical and the commoner presentations, the idea of a psychiatric hospital

as a therapeutic community and what happens to the patients when they return to the wider community. This last can best be done with the aid of general practitioners and mental welfare officers; the whole range of problems which arise when the mentally-ill patient is discharged could be studied in detail.

The psychiatric department and its staff must play a major part in teaching, but 'in addition to teaching on mental disorders the psychiatrist might be expected in the non-psychiatric wards (i) to co-operate in the techniques of interviewing and eliciting information from the patient; (ii) to indicate the clinical significance of the patient's life-history and personality development; (iii) to help introduce the students to the relevance of sociocultural data; (iv) to demonstrate something of the way in which physicians project their own feelings into problems arising in the course of medical practice[17].' There is a place in this country for teachers with advanced and equal training both in medicine and dynamic psychiatry as at Baltimore, Boston and Rochester (U.S.A.).[18]

Medical and psychiatric registrars in teaching hospitals would benefit from spending at least six months in a general practice as part of their own training. This should be a condition of their appointment to posts in which they have a heavy responsibility for the realistic teaching of medical students.

Every patient that is clerked by the student should have a psychological and social assessment, no matter what the diagnosis. Special attention must be paid to the psychosomatic disorders. For instance, a patient with asthma would be considered to be inefficiently clerked if the psychological stimulus was not defined with reasonable clarity. In order to do this radical changes would have to be made. Medical and psychiatric social workers must be brought much more closely into the teaching work of the teaching hospital; and at the same time the student must have place and opportunity for interviewing his patients by himself, and at length.

This approach will, however, by bringing the student more closely into contact with his patients tend to generate anxiety within himself, and he will need much greater support than is now customary. Although this may present difficulties, it is not an excuse for avoiding them; the British Medical Students' Association[19] make it plain that adverse reactions are being produced even under the present system, by plunging undergraduates unsupported into the deep waters of emotional, sexual and personal problems which they inevitably meet.

Social workers might co-operate with consultants in running a service for the students by organizing seminars in which they might air the anxieties arising from their contacts with patients and alleviate

them by sharing within the group. In this way the student would be supported in a practical way and would learn much about social work and group methods.

A long-term attachment to a general practitioner who has acquired the necessary attitudes and skills would enable him to see the effects of these concepts in practice, especially with a view to preventive work. It is only in the setting of general practice that the earliest signs of abnormality are likely to be observed and it is here that intelligent understanding of 'whole-person pathology' will pay the highest dividends. The student will see for himself how expensive special investigations and surgical procedures may be avoided by understanding the patient and his family. Moreover he will see how it is first necessary for the doctor to understand the patient's suffering, and having understood it with intellect and feeling, to withdraw to a professional distance so as to show the patient his difficulty. In these ways the student will gradually come to understand Balint's[20] concept that the doctor himself is a potent medicine that must be administered in the correct dose.

IV

EARLY POSTGRADUATE EDUCATION

The present position

The need for vocational training in general practice is now recognized and the subject has been considered in recent years both by the World Health Organization[21 22] and the Royal College of General Practitioners.[23] The College report recommends that there should be accepted minimum requirements of training starting with those aspects of hospital medicine most relevant to general practice and proceeding to apprenticeship in practice. The period of training should last five years; three to be spent in hospital and two in training practices. During the last two years the trainee doctor should be termed 'registrar'.

In both these reports training in psychological medicine is con-

sidered of particular relevance and importance. The second W.H.O. report states:

'In the past, skill in handling psychological, social and economic problems of patients has been acquired more or less spontaneously. They should now be part of the basic preparation of all physicians, both general practitioners and specialists.'

The College report states:

'His (the general practitioner's) essential task is the assessment of problems which are presented by patients and families in his care. Such assessments demand an understanding of the psychological, social and economic factors which influence health and disease as well as an understanding of physical pathology.'

The College report suggests that training in this aspect of medicine might include a hospital appointment, especially outpatient experience, during the second hospital year; practical experience of, and help in dealing with, psychiatric and psychosomatic disorders during the first year in a training practice; participation in seminars or clinical assistantships during the second year in practice; and the establishment in every region of courses to teach those general-practice subjects that are not adequately covered in hospital training or experience.

What training is at present available? Suitable junior hospital appointments do exist but are believed to be few in number.

A recent College survey (unpublished) shows that in Kent, Surrey and Sussex there are only eight senior house-officer and house-officer posts in psychiatry although these counties contain several of the large psychiatric hospitals which serve Greater London. Yet there are 64 registrar posts in the same hospitals. The small ratio of house-officer to registrar and junior hospital medical-officer posts is similar in the Liverpool and Manchester Regional Hospital Board areas. Information is not yet available from other areas, but it seems likely that the position is the same. Since registrar posts are not suitable because of their length for general practitioners in training, there is a need for a new type of post designed for this purpose at senior house-officer grade. Details of such a post at Bristol Royal Infirmary are given in Appendix III.

The degree of practical training and instruction in psychological and psychosomatic problems in training practices must depend on the bias of the trainer.

Vocational training courses have now been organized in London, Wessex and Canterbury, and the proportion of psychological and social medicine in these courses is high, from 20 per cent to 40 per cent. These courses are extended; teaching takes place on one day, or one half-day a week, for one or two years. Seminars of the Tavistock Clinic pattern continue to be held in several areas; whilst certain formal postgraduate courses in psychiatry, notably the

annual Ipswich course in family psychiatry, are also relevant to vocational training.

Future needs

(1) *Aims*

(*a*) To equip the young doctor with the knowledge, attitudes and skills which he will need to deal with the problems of human realtionship and the psychiatric disorders which he will commonly meet as a general practitioner.

(*b*) To make him more aware of the psychological component of all disorders and the psychological implications of the doctor-patient relationship.

(*c*) To make him aware of his own capabilities and limitations so that diagnosis, management and referral become more conscious acts.

(*d*) To avoid overburdening him with responsibilities better left to others or difficult to fulfil when manpower, time and money are limited.

(*e*) To build on what he has learnt in the undergraduate and pre-registration periods, and to relate training in these subjects to the rest of his early postgraduate vocational training.

(2) *Content*

It has proved convenient in stating the overall content of special vocational training for general practitioners to divide the whole field into three parts. The same divisions are used here:

Basic subjects
Techniques and responsibilities
Psychiatric disorders in the context of general practice.

A tabulated statement of training content is given in Appendix III, but by itself it fails to highlight the things that are important. The vital themes that must continually be taught to the young general practitioner are these:

Throughout his working life his task is to help people with problems. He needs help in relating to people as well as help in trying to solve their problems. Some problems involve more than one person in a family; these test his skill in relationship most of all.

We need to increase his awareness of emotional suffering. He must be alert to the possibility of anxiety, depression or psychological abnormality in every patient. These factors may complicate any medical problem; in different cases they may be of great or of trivial importance but they must always be looked for and assessed. The patient's natural inhibitions and the limitations of undergraduate medical education combine to conceal them. The young

doctor must be taught that emotional suffering can sometimes be of greater or more enduring importance to the patient than physical pain.

A broad approach to the causation of emotional suffering and mental disorders must be taught. Physical, psychological and sociological factors are each important in different cases. To assess the importance of such different factors in the total problem of a particular patient is one of the hardest tasks but it is the duty of any doctor who attempts to take a balanced view. Teaching must prepare for this role by presenting crucial examples from each approach.

Theoretical knowledge is valuable, but it is not enough. The central point of training, as of practice, is the consultation between patient and doctor. Nothing helps the young general practitioner more than discussion of the problems of the patients he is beginning to treat and his own problems in their assessment and management. If he is to venture into this difficult and uncertain part of medicine, he needs both intellectual guidance and emotional support. Whoever supports him must draw out his fears. Every young doctor who attempts seriously to face human problems has inevitably to cope with feelings of uncertainty and inadequacy.

One more theme must pervade all our teaching. This subject may be difficult but it is for that very reason of great interest and challenge. There is no laboratory that offers better opportunity for its study than general practice.

(3) *Methods and teachers*

The principal method of training is for the novice to take increasing responsibility under supervision, at first as a resident in hospital, then as an assistant in general practice, with ample time and opportunity for discussion with his teachers and colleagues.

The hospital post likely to be of most value is one in an active psychiatric unit in a general hospital. Outpatient and day hospital experience are also appropriate. In most psychiatric hospitals a senior house-officer post would be of limited help, unless specially designed for the training of a general practitioner. Residents should have the opportunity to meet, and learn from, general practitioners. This could be arranged by family doctors coming to the hospital to teach on topics from the standpoint of general practice, or presenting their patients at case conferences. An experienced general practitioner might be on the staff as lecturer or clinical assistant. Residents could accompany their chiefs on domiciliary consultations.

In the years in training practices the ideal method of gaining practical experience in the management of psychological problems

is for the registrar to have the opportunity of working for three to six months with a psychiatrically orientated principal, especially if the practice also has a skilled social worker.

Discussion at regular intervals between teacher and registrar of the registrar's own cases is the best method; his special problems in relating to patients and the particular patients whom he is trying to help form the material for discussion; follow-up is important. The registrar also gains by sitting in with the principal and watching his handling of this type of case and this aspect of all cases (the value depending on the attitude and skill of the principal). The registrar can also be asked to interview patients known to the principal whose case-histories are particularly typical or instructive for some other reason such as successful outcome, unusual features, a masked presentation, a particularly difficult personality. But after such demonstration, there must be discussion.

During the first year in a training practice, the registrar should attend a vocational training course and, if time permits, a course in family psychiatry such as that at Ipswich during the first or second year.

The second-year registrar can increase his skill and understanding in dealing with emotional problems and psychological illness by taking part in a seminar of the Tavistock Clinic type. Alternatively, he might hold a clinical assistantship or carry out research. Indeed, research projects can usefully be combined with group seminar training. Another valuable method is the attachment of psychiatrists to teaching practices to attend at regular intervals to discuss with the doctors some of the problems they are treating.[24]

It is in the second year of general practice training, when he is taking increasing responsibility for the care of patients and, in addition, is beginning to experience the stresses and strains of family life himself, that the young doctor is most likely to benefit from the insight-giving qualities of group discipline. He will become aware of his abilities, limitations and emotional blind-spots, and thus be enabled to use the doctor-patient relationship as a rational diagnostic and therapeutic process.

However, attendance at a seminar is best confined to volunteers since it has been shown[25] that only a minority of doctors can tolerate and benefit from this type of training. It should if possible continue for two to three years and is therefore particularly suitable where a registrar settles as a junior principal in the same neighbourhood.

(4) *Minimum requirements for postgraduate vocational training* (human relationships and psychiatry).

A three-month house appointment in a psychiatric department *or*

weekly attendance as clinical assistant in a psychiatric outpatient clinic for a year *and* two years' experience in training practices *and* attendance at an organized introductory course on general practice of not less than 30 half-day sessions *or* attendance at a course of approved seminars of Tavistock type, *or* a formal course in psychiatry of not less than two weeks.

V

CONTINUING POSTGRADUATE EDUCATION

The keen doctor is a perpetual student who will always find ways of keeping his knowledge up to date. Nevertheless it will be important to provide for his needs in each geographical area, and this means the continuance and extension of existing educational facilities; however effective undergraduate education and special vocational training may become, the need for continuing education will remain.

Personal contact with the psychiatric services of the area is one of the most fruitful ways of keeping up to date. The practitioner should become well acquainted with the psychiatrists, mental welfare officers, and psychiatric social workers in his area. Attendance at domiciliary consultations is valuable for its two-way discourse between colleagues.

Other educational methods are:

(1) Discussion groups. The best known of these is the Balint (or 'Tavistock') type of seminar already described. Varieties of this method occur, some doctors valuing the presence of psychiatric social workers, health visitors, and general physicians at their meetings. The encouragement of these discussion groups for volunteers is strongly recommended.

(2) Clinical meetings and case conferences where general practitioners read papers and present their own cases.

(3) Clinical assistantships in psychiatric hospitals and departments.

(4) Formal postgraduate courses are valuable but need modifying to suit the special needs of family practice. Some of the common problems of practice need full discussion, and whenever possible experienced general practitioners should be asked to participate in teaching seminars and symposia.

(5) Access to libraries of books, journals and tape recordings—preferably by postal service.

(6) Research. Individual and group analyses of different types of psychiatric

disorder met with in practice, their prognosis and response to different drugs and therapies are educational in the widest sense.

Some of the methods discussed in the next section for courting the uninterested apply as much or more to refresher education as to special vocational training.

VI

COURTING THE UNINTERESTED

The working party paid particular attention to the reasons why the interest of different general practitioners in this part of medicine varies so greatly and to what can be done about attracting those who are uninterested. The best hope of change lies in education.

A small proportion of general practitioners who at present have no use for psychiatry will prove resistant to any attempt to influence them on this subject, but there is a much larger group who might change their negative or hostile attitudes if attractive educational schemes or suitable incentives were offered to them. Lack of interest reflects partly fear, partly the inherent difficulties of the subject and partly the shortcomings of undergraduate education and the absence of any further preparation for general practice.

The personality of the student who makes general practice his life's work is important; he must like people. Science without humanity does not make for good medical practice. Selection methods both for medical students and later for general practitioners should embody this truism.

The long-term solutions of this problem start even before the selection of medical students with the type of education that they receive at school. The biological and physical sciences must give some place to the humanities. Universities by modifying their requirements for entry to medical schools could achieve this change. Selectors of students need to find reliable ways of judging character and interests, to add to the present dependence on examination results (usually in biological and physical sciences alone). Thereafter the laying of proper foundations in interest and attitudes during the undergraduate period is of fundamental importance for all that follows. Once a student is unduly biassed towards the physical

aspects of medicine, it is far harder to change his attitude at any later stage. All the recommendations made in Part IIA (Undergraduate Education) of this report are relevant to the present question.

Not all general practitioners make a positive choice of their career at present. There is certainly no positive selection for general practice. But there needs to be. No one should be encouraged to enter this specialty if he or his teachers have any reservations about his aptitude for human relationships and his interest in people.[27 28] A period of three or four years early postgraduate training for general practice is likely to become a reality in the near future as part of a national plan for the postgraduate preparation of all doctors. Some form of career guidance is also probable. Selection for general practice may soon be attempted.

In the shorter term—once the doctor is training for or has entered practice—the methods adopted must aim to increase his interest and competence. Many uninterested doctors who feel that much of their work is 'trivial' and resent 'unnecessary calls' and 'late calls' can be helped to recognize the previously unobserved psychological factors in all these cases and thereby find their work in future more interesting and rewarding.[29 30 31 32] Many doctors are curiously unaware of the essential nature of the doctor-patient relationship in general practice. In this relationship there is always a partial emotional involvement on the part of the doctor. The good general practitioner is never 'detached'; he cares for his patient. Two quotations illustrate successful education of previously uninterested practitioners:

'Patients who had been a pain in the neck to me have now become a source of interest.'

'The discussions . . . have opened up a new field of medicine to me'.

The following methods of arousing interest are suggested:

Directly educational methods

1. Discussion of common symptoms, such as headache, chest pain, abdominal pain, which may prove to have either an organic or psychogenic basis.

2. Discussion of the handling of 'normal' people and 'normal' anxieties.

3. Starting teaching on psychiatry with discussion of the recognition and management of psychosis, especially for older general practitioners. The analogies with their approach to the rest of medicine are much closer than for neurosis.

4. Teaching about the simpler and shorter case-examples if possible drawn from a general practice setting, with a fair proportion of successful results.

5. Advocating the value of the long interview in general practice as a method worthy of trial. The recent increase in appointment systems makes this more possible.

6. Presenting the more difficult parts of the subject, e.g. neurosis—as a challenge. Total success is uncommon in treatment and relapse common.

Teachers should take great care not to overplay their hand.

7. The introduction of psychiatric topics into courses on general medicine and specialties such as dermatology or rheumatology.

8. Teaching on psychiatric topics by non-psychiatrists, e.g. gynaecologists, general physicians, general practitioners. There has been an increase in the number of general practitioners who have experience and skill in teaching in this field, though there are still not enough. There is a special place for case discussions between general practitioners and social workers or health visitors where they are accustomed to working together.

Indirect methods of educational value

1. Domiciliary visits by psychiatrists in the general practitioner's presence.

2. Attachment of a psychiatrist to a group practice for regular visits.[24]

3. Case-conferences at the psychiatric hospital on a case referred by a general practitioner and before discharge home. The general practitioner should be paid to attend just as a consultant is paid to make a domiciliary visit.

4. The use by psychiatrists of a short questionnaire to the general practitioner when a patient is referred by him without adequate prior description. This not only increases the general practitioner's involvement but may decide him to manage some cases himself after all.

5. Involvement in a group research project on a psychiatric topic.

The increase and improvement of psychiatric services in an area favours greater recognition of these problems by the local general practitioners.[33] Eventual reduction in list size nationally, a goal desired by all on many other grounds, would favour this aspect of medicine since these patients attend more frequently and exhibit higher rates of general morbidity and more categories of illness per head than other patients.[2]

Summary

This report, after a short description of the general practitioner's role, comments on the undergraduate curriculum of all doctors in psychology and psychiatry (and analyses the present teaching in medical schools in an appendix). The early postgraduate training of future general practitioners in these subjects is discussed in detail.

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APPENDIX I

A SAMPLE OPINION OF GENERAL PRACTITIONERS ON THEIR NEEDS FOR EDUCATION IN PSYCHIATRY, PSYCHOLOGY, AND A KNOWLEDGE OF HUMAN RELATIONSHIPS IN FAMILY PRACTICE

Questionnaires were sent out to all Leicestershire and some Yorkshire general practitioners. Their opinions were sought about their own education in human relations, psychology and psychiatry; their needs for postgraduate education in these subjects, and what they would wish their successors in general practice to be taught.

Methods

A preliminary questionnaire was sent to all the 174 general practitioners in Leicestershire. It asked their opinion of their own preclinical and clinical training, and their need for postgraduate education. The questions were posed in such a way as to conceal our special concern with human relationships and psychiatry. There was a 50 per cent response from doctors who qualified from 1903–1961 (87 doctors).

A second questionnaire was sent to (*a*) 75 general practitioners in Leicestershire who, in their replies to the first questionnaire had shown that they rated psychiatry of some importance in their own sphere of work. There were 62 replies. (*b*) 90 practitioners who had attended or expressed a desire to attend a weekend postgraduate refresher course in psychiatry at York in the summer of 1965 were circulated. From these there were 63 replies. There were thus two equal groups of doctors both selected because of their interest in this subject.

Results

FIRST QUESTIONNAIRE

(*a*) *About their own training*

1. *Preclinical.* The following six subjects were listed: anatomy, pathology, pharmacology, physiology, psychology and sociology. Only 52 per cent of those replying had been taught psychology and 13 per cent sociology. When asked to compare their enjoyment of these subjects, they rated psychology fourth and sociology fifth, but the numbers for the latter subject were too small to be significant. Pharmacology was sixth. When asked to compare the merit of the teaching in the same six subjects, they rated psychology fifth and sociology sixth.

2. *Clinical.* Nine subjects were listed: *general medicine*, *general surgery*, *obstetrics*, *paediatrics*, *psychiatry*, human relationships, general

practice, preventive medicine and first aid. The results were considered only reliable for the five in italics. In fact human relationships were taught to only five per cent, but all but 12 per cent had been taught psychiatry. Psychiatry ranked last in the five subjects in italics, both in popularity and in the merit of teaching.

(*b*) *About needs for postgraduate training*

Some 88 per cent of the general practitioners replied that they felt in need of further training in some subjects. Among the nine subjects listed human relationships ranked eighth and psychiatry fourth. The full order was:

(1) General medicine
(2) Paediatrics
(3) Obstetrics
(4) Psychiatry
(5) General surgery
(6) Preventive medicine
(7) General practice
(8) Human relationships
(9) First aid

Only the first five subjects can be looked on as an accurate reflection of the feelings of doctors, the last four being on too small numbers.

(*c*) *About the needs for general practitioners of the future*

The opinion of the doctors was asked what they considered should be taught to medical students, if medical education were designed to train general practitioners. General medicine headed the list, psychiatry came third, general practice itself fifth, and human relationships seventh among the nine subjects.

SECOND QUESTIONNAIRE

This was an attempt to measure the general practitioners' assessment of their own ability to cope with various human relationships and psychiatric problems, and their desire for further education in each type of problem.

The questionnaire listed 20 problems in these subjects and sought the doctors' opinions about their prevalence, their ability to cope with them, and their desire for further training directed at each problem. The types of problem were as follows:

The frequent attender
Schoolphobia
Sad people
Worried mothers
Chronic insomnia
The mentally handicapped
The menopausal woman
The aggressive patient
The dying patient
Tired people
The stuttering child
Suicidal threats
The alcoholic
The dependent patient
The frigid wife
The hypochondriac
Anxious people
Discharged schizophrenics
The annoying patient
The senile dement

There was considerable agreement between the general practitioners of the two countries as to the importance of the individual problems, but there was a great variation as regards the need for further education on the listed subjects. The figures varied from 64 per cent to 15 per cent.

The doctors felt best able to cope, and therefore least in need of further training, for the following subjects:

(1) Dying patients
(2) The frequent attender
(3) Worried mothers
(4) Aggressive patients
(5) Annoying patients
(6) Menopausal women
(7) Schoolphobia
(8) Dependent patients
(9) Sad people
(10) Tired people

All but two of these problems were reckoned to occur commonly. There is thus a clear correlation with prevalence. It seems that general practitioners feel that they learn to cope from experience. The need for further training was highest for the following problems, in that about half or more of the doctors felt postgraduate education in the subjects would be of value:

(1) The alcoholic
(2) The stuttering child
(3) Frigid wives
(4) Discharged schizophrenics
(5) Suicidal threats
(6) The hypochondriac
(7) Mentally handicapped
(8) Anxious people
(9) Chronic insomnia
(10) Senile dements

It is notable that all these problems were found by both groups to occur only rarely, except anxious people, hypochondriacs, and people with chronic insomnia. These three groups were quoted as an educational need by more than half of the doctors in Yorkshire, but not in Leicestershire, although the latter agreed that they are common problems. As might be expected, there was a good correlation between the inability to cope and the need for further training, and *vice versa*.

The Yorkshire doctors, probably because they came from a group professing a special interest in psychiatry, showed a slightly greater overall desire for further training.

APPENDIX II

THE TEACHING OF PSYCHIATRY IN MEDICAL SCHOOLS

The material in this appendix is extracted from the replies to questionnaires sent to professors of psychiatry and other heads of psychiatric departments in the 31 medical schools in the British Isles. All but one questionnaire were completed and returned (*see* table I).

TABLE I

Hospital or university	*London*
1. Charing Cross	(Dr J. B. Randell)
2. Guy's	(Dr D. Stafford Clark)
3. King's College	(Dr D. W. Liddell)
4. London	(Prof D. Pond)
5. Middlesex	(Prof Sir Denis Hill and Prof J. M. Hinton)
6. Royal Free	(Dr S. W. Hardwick)
7. St Bartholomew's	(Prof Linford Rees)
8. St George's	(Prof D. Curran)
9. St Mary's	(Dr J. D. W. Pearce)
10. St Thomas'	(Dr W. W. Sargant)
11. University College (Hospital)	(Dr R. F. Tredgold)
12. Westminster	(Dr G. Garmany)
	Midland region
13. Birmingham	(Prof W. H. Trethowan)
14. Bristol	(Prof D. Russell Davis)
15. Oxford	(Dr B. Mandelbrote)
	Northern region
16. Leeds	(Prof M. Hamilton)
17. Liverpool	(Prof F. J. Fish)
18. Manchester	(Prof W. I. N. Kessel)
19. Newcastle	(Prof M. Roth)
20. Sheffield	(Prof E. Stengel)
	Eire
21. Cork	(Dr MacCarthy)
22. Galway	(Dr J. R. J. Shea)
23. Trinity, Dublin	(Dr H. J. Eustace)
24. University College, Dublin	(Prof J. Dunne)
	Northern Ireland
25. Belfast	(Prof J. G. Gibson)
	Scotland
26. Aberdeen	(Prof W. M. Millar)
27. Edinburgh	(Prof G. M. Carstairs)
28. Glasgow	(Prof T. Ferguson Rodger)
29. St Andrews	(Prof I. R. C. Batchelor)
	Wales
30. Cardiff	(Prof K. Rawnsley)
31. Cambridge	Details not available

1(*a*) *Is there any preclinical instruction in psychology or sociology? If so, which of the following are taught—experimental psychology, physiological psychology, psychology of human development, psychodynamics, sociology?*

These subjects are not taught in seven medical schools during the preclinical course (*see* table II), although there are only three medical schools without preclinical departments.

In one other medical school, Trinity, Dublin, psychology and sociology are taught only to students specializing for a B.A. degree.

TABLE II

Medical schools without preclinical instruction in psychology and sociology

Medical schools without preclinical department	*Medical schools with preclinical department but no instruction*
St George's	Cardiff
University College Hospital	Galway
Westminster	London
	St Thomas'
Psychology and sociology taught only to students specialising for a B.A. degree	
Trinity, Dublin	

The teaching in psychology and sociology in the remaining 22 schools is very varied in terms of time spent on these subjects and the content. Details are shown in Section (*a*) of table VII, (*see* page 38).

Only seven schools indicated on the questionnaires that sociology is taught in the preclinical period (St Bartholomew's, Bristol, Liverpool, Newcastle, Cork, Aberdeen, Edinburgh), and one school (Leeds) offers an elective course for 1st M.B. students. Fourteen schools state that they do not teach sociology, although one of these does include a special B.A. course which includes sociology.

Four schools did not state whether they do or do not teach sociology, though one of these indicated that there used to be a course in sociology during the clinical studies.

Of the seven schools teaching sociology, one allows one hour on the subject, while another spends 20 hours. Four others include the subject in the totals of the teaching time allowed for psychology and sociology.

In only one school is there reference to a physician in social medicine.

1 (*b*) *Is teaching by lectures, seminars, practical work?*

Twelve of the 22 schools teaching psychology and sociology during the preclinical period use lectures only.

Of the other ten, seven schools teach by using seminars in which the

students participate, and there is practical work in five schools in addition to formal lectures.

In only one questionnaire is there specific mention of the use of films and demonstrations in addition to lectures and seminars.

1 (*c*) *Who teaches these subjects?*

There is a remarkable range of teachers, but mostly the teaching is done by consultant psychiatrists or physicians in psychological medicine, together with clinical psychologists. In eight questionnaires the teachers are stated as "The staff of the psychiatric department" or "Staff of the department of mental health". In others, individuals are named and their titles not given. Three schools state that teaching is done by lecturers in psychiatry, and in two others by lecturers in psychology. Senior and other registrars are mentioned once only, as also is an experimental psychologist, a child psychiatrist, a psychotherapist, a physician in social medicine, an anthropologist, and a lawyer. In one school the professor of philosophy gives the whole of its preclinical course in psychology. In only six schools is there specific mention of the professor of psychiatry or psychological medicine as taking an active part in the teaching of psychology and associated subjects during the preclinical course.

London has lagged behind the provinces in establishing chairs in psychiatry. Whereas there are chairs in psychiatry or psychological medicine in 15 of the 18 medical schools outside London, there are only four chairs in psychiatry out of the 12 London medical schools, and, of these, two will have been established during the time that this survey has been conducted.

1 (*d*) *Do preclinical students have demonstrations of patients' problems?*

Patients' problems are demonstrated to preclinical students in only six of the 30 medical schools; the details are shown in table III.

TABLE III

Demonstrations of patients' problems for preclinical students

Hospital reference numbers (see table I)		*Total*
2, 5, 15, 20, 26, 27	Yes	6
1, 3, 6, 7, 9, 13, 14, 16, 17, 18, 19, 21, 24, 25, 28, 29	No	16
8, 11, 12	No preclinical department	3
4, 10, 22, 30	Preclinical department, but psychology not taught	4
23	Special B.A. course only	1

1 (*e*) *Total number of hours teaching of all the above subjects in preclinical course*

Only eight of the medical schools devote more than 25 hours to the

teaching of psychology and sociology to preclinical students, but no answers were given by two schools. *See* table VII, section (*a*).

1 (*f*) *Are you satisfied with this course? Please comment*

Only three medical schools answered this question in the affirmative—Leeds, Liverpool, and Aberdeen. No comment was made by St George's, Westminster, Manchester, Newcastle, Sheffield, Trinity, Dublin and Cardiff.

The remaining 20 schools expressed their dissatisfaction with their present preclinical teaching of psychology and sociology.

Included in the comments made at the end of the answers to the first question, there are several references to "Some authorities need to be convinced of the need to widen the curriculum", and "There is not *nearly* sufficient time for such important subjects." Another comment reads "Further teaching time is desirable for the teaching of fundamentals of psychology as applied to medicine". One of the most biting comments is "Anatomy and physiology teach more than 350 hours each; we are clearly still an under-privileged subject".

Several references are made to the intention of extending this part of the course, and to the intention of reviewing the whole syllabus in the near future.

Other comments refer to the shortage of staff, of space, and the need for more time.

Reference is also made in two of the questionnaires to the lack of orientation of psychology to general medicine, and, in one case, separation of the medical school from its main hospital is given as a factor in making it difficult to integrate into clinical needs.

In several questionnaires reference is made to the need for the inclusion of the 'behavioural sciences' in the medical curriculum.

Reference is made by Professor W. H. Trethowan (Birmingham)[10] to his survey of the teaching of these subjects in the British Commonwealth medical schools, and in medical schools in America and Canada. "The usual procedure in most American and Canadian schools is to give fairly extensive courses in personality development, psychodynamics, etc., during the first or second pre-medical years" . . . e.g. University of Toronto gives three hours of psychology and three hours of anthropology *per week*, during the second preclinical year.

Table IV shows the percentage of time spent in various medical schools on the teaching of psychology and psychiatry in the preclinical period in Canada, the U.S.A., and in the London hospitals investigated.

TABLE IV
(*After W. H. Trethowan, 1960*)

Percentage of time spent on preclinical teaching of psychology and psychiatry	Canada: *19* U.S.A.: *14* London: *3*

Undoubtedly, there are many ways of teaching psychology to the preclinical student. Two schools gave particularly interesting details of the content of their courses in answer to this questionnaire—the Middlesex[34] and Sheffield.[35]

Professor E. Stengel[35] gives details of the preclinical course on human behaviour at Sheffield. The main principal emerging here is that:

> There should be a preclinical course in psychology side by side with anatomy and physiology, with special consideration of those aspects which are relevant for the medical student. Such a course would provide basic knowledge for the study of abnormal behaviour . . . It is hoped that the preclinical course in psychology will create respect for, and a general interest in what is peculiarly human in the patient. At the same time, the student will learn a great deal about himself in this preclinical course.

2 *Psychiatry and psychosomatic disorders—(a) number of hours devoted to each; (b) number of lectures; (c) number of demonstrations; (d) are seminars (group discussions) used? If so, how many hours; (e) do students have opportunity for clerking patients with psychiatric and psychosomatic disorders; If so, for how long? (f) who teaches the subject?*

There is differentiation between the number of hours devoted to psychiatry and psychosomatic disorders in only two questionnaires. Of the rest, 20 show the number of hours devoted to these two subjects together. These times vary greatly—the highest number being 250 hours (Birmingham and Middlesex) and 240 (St Mary's from November 1966).

In five questionnaires the answers to section 2 (*a*) are given in terms of months. Three state one month, with one of them qualifiying this time by stating it is spent as an intern. Two other schools give the time devoted to psychiatry and psychosomatic disorders as three months, but one of them states this to be a clinical appointment. These details are shown in section (*b*) in table VII, which also shows details of the use of demonstrations and seminars.

A comparison of the answers given in these questionnaires with the report published by the British Medical Students' Association in 1959[36] shows that there has been some improvement in some schools over the past few years.

Only two schools refer to separate lectures on psychosomatic disorders: Trinity, Dublin, arranges six lectures, and Guy's arranges four clinical lectures on this subject.

All but one of the schools provide the opportunity for students to clerk patients with psychiatric disorders.

3 *Is there any teaching on subnormality? If so, how many hours?*

Although the problem of subnormality rarely occurs in any individual general practice every school devotes time to teaching this subject. One school devotes three hours during the preclinical course and a further 20 hours later during the clinical period. Table V shows the time devoted to the teaching on subnormality by all schools.

TABLE V

Medical school number	*Time*
1: 3: 7: 8: 11: 15: 17: 19	2–3 hours
6: 10: 21: 23: 26: 27: 28: 30	3½–4½ hours
4: 9: 22: 24: 25	5–6 hours
16: 29	8–10 hours
20	20 hours
13	1½ days
14	"A good deal"
18	4 hours plus 1 day visit
2: 12	No specific time

4 (*a*) *Do students obtain any experience of psychotherapy for patients with psychiatric and psychosomatic illness? By observation—direct, one way screen, television, film?*

Half of the schools provide some teaching of psychotherapy—the details of some of the methods used are given in part (*c*) of table VII. In a small number of schools one-way screens, closed-circuit television and films are used.

4 (*b*) *By supervised responsibility for patients?*

This opportunity is allowed in ten schools (*see* part (*c*), table VII).

4 (*c*) *By theory only/mainly?*

Details are shown in part (*c*), table VII.

5 (*a*) *Is there any combined teaching with medical, surgical or other firms on the psychological aspects of patients in the general wards? How many hours?*

There is combined teaching in less than half of the schools—in only 14 of them. The number of hours stated varies from two to 30, but these details are given by only six schools.

5 (*b*) *Is there any teaching on the psychological disorders which are presented to obstetricians, paediatricians, geriatricians, general practitioners?*

The replies are to be seen in table VI.

6 *Are there any other methods used by your school in the teaching of psychiatry not included above?*

Only one medical school (Guy's) has its own students' psychological

TABLE VI

	No	*Yes*
Obstetricians	12	8
Paediatricians	9	11
Geriatricians	11	9
General practitioners	6	15

(Two replied "only incidental")

society. Apart from this the variation in answers is enormous and details are given in part (*d*), table VII.

7 *Is there any examination (or part of examination) in psychiatry? (a) Who is the examiner, psychiatrist or other physician? (b) What examination methods are used—written, oral, clinical?*

Only two schools have no examinations in psychiatry (King's College and Westminster), but in several of the others it is part of the final qualifying examination and the questions are not obligatory in all cases. There are prize-examinations in psychiatry in 12 schools (Guy's, King's College, Middlesex, St George's, St Mary's, St Thomas', Leeds, Sheffield, Newcastle, Aberdeen, Glasgow, and Trinity, Dublin). One other school (St Bartholomew's) is starting a prize-examination in October 1967. Other details are given in table VII (*e*) on page 45.

8 *Is there any opportunity for students to see general practice during their training? Voluntary or obligatory? For how long?*

Five schools state a definite 'no' (St George's, Cork; Trinity, Dublin; University College, Dublin; and Belfast). Sixteen schools allow an optional attendance-scheme for general practice observation and in only eight schools (Charing Cross, King's College, Oxford, Leeds, Newcastle, Sheffield, Aberdeen, Edinburgh) is attendance compulsory.

Methods of general-practitioner attachment vary but are outside the remit of this enquiry, even though the Working Party feel strongly that this part of the undergraduate medical student's education is particularly valuable to him.

9 *Is any course available for postgraduate education in psychiatry (including psychosomatic disorders) for general practitioners? If so, is it part of a general postgraduate course or a special course provided by your department?*

Only three schools offer no postgraduate training in psychiatry (King's College, St George's, Cork); one school (Trinity, Dublin) did not answer this question; all the rest offer some form of postgraduate training, mostly in general courses rather than in special psychiatric courses.

10 *Would you care to outline any further developments in the teaching of psychology and psychiatry (including psychosomatic disorders) which you wish in future to introduce, (a) for undergraduates (b) for general practitioner postgraduates?*

Eighteen schools answered this question.

Preclinical

One school is about to introduce a new programme spaced throughout the preclinical and clinical course, starting with 'behavioural science' in the first preclinical year. There will be a strong sociological bias.

Another school plans a three-year preclinical course including behavioural sciences leading to a B.Sc. degree.

One school is considering an examination in general psychology at the end of the preclinical period.

Clinical

The most frequent proposal is an increase in the period of clerkship on psychiatric patients (four schools). Three schools also want to spread psychiatric instruction over the whole clinical period. Two schools want more teaching in the general wards to undergraduates, housemen and registrars.

One school plans a one-day course in psychiatry for general medical consultants. One plans topic teaching jointly with physicians and surgeons, in order to teach the psychosomatic aspects of medicine. Two schools want a regular obligatory question in the final examination. One school proposes domiciliary visits as part of the training curriculum. Another school which runs a Tavistock-type seminar for students wants to start more. Two more London schools plan professorial units. Another has recently opened a psychiatric unit with a force of 80 beds at a neighbouring hospital, where a large part of the teaching will take place. This unit will provide a comprehensive service for the community and students will have an opportunity to attend domiciliary consultations and see the work of general practitioners, mental welfare officers, medical officers of health and voluntary bodies.

Postgraduate

Three schools want more clinical attachments for postgraduates. One wants six-month registrar posts for general practitioners as part of their special vocational training. One school wants to maintain and develop its existing activity in producing postgraduate refresher courses for general practitioners, tapes, films, and closed-circuit television (including the demonstration of psychotherapy).

TABLE VII

Section (*a*)

No.	*Hospital*	*No. of hours preclinical teaching of psychology and sociology*
1	Charing Cross	10
2	Guy's	16
3	King's College	10
4	London	Nil
5	Middlesex	28
6	Royal Free	6
7	St Bartholomew's ..	10 (to be increased to 16 in October 1967)
8	St George's	No preclinical school
9	St Mary's	10
10	St Thomas'	Nil
11	University College Hospital	No preclinical school
12	Westminster	No preclinical school
13	Birmingham	8
14	Bristol	26 (88 in 1967)
15	Oxford	12
16	Leeds	40
17	Liverpool	90
18	Manchester	15 (new, enlarged programme next year)
19	Newcastle	43
20	Sheffield	42
21	Cork	40
22	Galway	15 (given during third medical year)
23	Trinity, Dublin	Only taught for special B.A. course
24	University College, Dublin	30

No.	*Hospital*	*No. of hours preclinical teaching of psychology and sociology*
25	Belfast	14
26	Aberdeen	Circa 50, but 100 if including neuro-anatomy, neurophysiology
27	Edinburgh	40
28	Glasgow	20
29	St Andrew's, Dundee ..	12
30	Cardiff	Nil

(*N.B.* The details given are as given in the 1966 questionnaires with some additional information received in 1967).

TABLE VII

Section (*b*)

No.	*Hospital*	*Number of hours devoted to psychiatry and psychosomatic disorders*
1	Charing Cross ..	Eight psychiatry, two psychosomatic disorders plus demonstrations in psychiatry and three months clinical appointment
2	Guy's	Fifteen psychiatry, four psychosomatic disorders plus three months clinical appointment and grand ward rounds
3	King's College ..	Both: 32 plus 40 hours in outpatients. Thirty-two hours seminars
4	London	Details not given
5	Middlesex ..	About 250 hours total in a 3/12 clerkship
6	Royal Free ..	One month full-time internship plus lectures 11 hours, demonstrations, visits to hospitals, etc.
7	St Bartholomew's	Both: 131 hours including 19 lectures, 67 demonstrations and 24 hours/seminars. (As from October 1967 all students will do psychiatry for three months full-time)
8	St George's ..	Both: 100 hours, including eight hours psychiatry lectures and six seminar hours
9	St Mary's	Both: 240 from November 1966—actually six weeks whole-time

No.	*Hospital*	*Number of hours devoted to psychiatry and psychosomatic disorders*
10	St Thomas' ..	Both: 112 (approximately) including four lectures, five demonstrations and four seminars for both in six weeks full-time
11	University College Hospital ..	Both: 200 minimum including 30 demonstrations, 72 seminars with 200 more optional
12	Westminster ..	One month full-time; 18 lectures, 12 demonstrations and 12 seminars
13	Birmingham ..	Both: 264 hours (approximately) including eight one-and-a-half hour lecture demonstrations in introductory clinical course; 16 one-and-a-half hour seminars in fourth year; 13 one hour lectures in fifth year; 30 three-quarter hour lecture demonstrations; six weeks clinical clerking, say 32 hours per week
14	Bristol	Three months full-time; including 20 lectures, 12 demonstrations and three hours/seminars
15	Oxford	One-hundred-and-eighty (approximately) including 20 lectures (approximately), 60 demonstrations (approximately) and 70 seminars (approximately)
16	Leeds	Both: 58½ hours, including 21 lectures, 45 demonstrations, 17 seminar/hours
17	Liverpool	Both: 30 plus including 20 lectures; 10 demonstrations and seminars in clinical demonstrations
18	Manchester ..	Both: about 70; including 30 lectures. (A greatly expanded curriculum starts next year)
19	Newcastle ..	Fifty-eight hours clinical lectures and demonstrations (including CNS course) 80 hours clinical work in fourth year. Four weeks whole-time clinical appointment in fifth year
20	Sheffield	Both: 175 including 42 lecture demonstrations
21	Cork	Both: 30
22	Galway	Both: 30
23	Trinity, Dublin ..	One month internship; including 12 lectures in psychoneuroses plus ten demonstrations in psychiatric outpatients in general hospitals

No.	*Hospital*	*Number of hours devoted to psychiatry and psychosomatic disorders*
24	University College, Dublin ..	Both: 30 including 16 lectures and 14 demonstrations
25	Belfast	Both: 52 including 17 lectures, six demonstrations and 12 seminars
26	Aberdeen	Both: 32 including lectures and demonstrations plus clerkship and variable seminars
27	Edinburgh ..	Both: 81 including 36 lectures, 30 demonstrations and 22½ hours/seminars
28	Glasgow	Both: 50 including 25 lectures, 19 demonstrations and 30 seminar/hours
29	St Andrew's, Dundee	Both: 90 including 21 lectures in adult psychiatry, six in child psychiatry, and five in mental deficiency
30	Cardiff	Both: 92 including 20 lectures

TABLE VII

Section (*c*)

EXPERIENCE OF PSYCHOTHERAPY

No.	*Hospital*	*Experience of psychotherapy*	(*i*) *By observation*	(*ii*) *With supervised responsibility*	(*iii*) *By theory*
1	Charing Cross ..	No		No	Only
2	Guy's	Yes	Yes	Yes	No
3	King's College ..	No "impractical—short of time"		No	Yes
4	London	Yes		Yes/optional	Mainly
5	Middlesex ..	Yes		Yes	Yes
6	Royal Free ..	Yes		Yes	Mainly
7	St Bartholomew's	Yes	Yes	Yes	Mainly
8	St George's ..	No		No	Only
9	St Mary's	Yes	Yes	No	Mainly

No.	*Hospital*	*Experience of psychotherapy*	*(i) By observation*	*(ii) With supervised responsibility*	*(iii) By theory*
10	St Thomas' ..	Yes		Yes	Partly
11	University College Hospital	Yes		Yes	As well
12	Westminster ..	Yes	Yes	Yes	
13	Birmingham ..	Yes	Yes	No	Yes
14	Bristol	Yes	Yes	Yes	No
15	Oxford	Yes	Yes	No	Mainly
16	Leeds	No		No	No
17	Liverpool	No		No	
18	Manchester ..	No		No	
19	Newcastle ..	Yes	Yes	No	Only
20	Sheffield	No		No	Only
21	Cork	Yes	Yes	No	Yes
22	Galway	Yes		Yes, when in residence	
23	Trinity, Dublin ..	No		No	No
24	University College, Dublin	Yes	Yes	No	
25	Belfast	No		No	Only
26	Aberdeen	Yes	Yes	No	Yes
27	Edinburgh ..	No		No	Only
28	Glasgow	No		No	Mainly
29	St Andrew's, Dundee	No		No	Only
30	Cardiff	No		No	Only

TABLE VII
Section (*d*)

No.	*Hospital*	*Extra teaching methods used*
1	Charing Cross ..	
2	Guy's	Students have started psychological society. Clinical meetings and invited lecturers
3	King's College ..	Regular seminars over eight weeks in child psychiatry, during paediatric clerking. Includes demonstrations of cases and combined teaching with paediatricians. IP clerking on adult firm
4	London	
5	Middlesex ..	Supervised history-taking and examination of new patients in OPD "preparation" of patients for psychotherapy by psychotherapist. Elective resident senior clerkship of 2/12 at end of course
6	Royal Free ..	Five-hour revision course in psychiatry offered just before final M.B. Also extra 1/12 elective period offered
7	St Bartholomew's	A fortnightly case-conference open to all students. Two weeks residence in a mental hospital. Films and tape recordings
8	St George's ..	1. Main method is by clerking of patients in IP and OP work, with discussion and criticism of this work 2. Students also visit mental hospitals to see individual patients and the style of working undertaken there
9	St Mary's	Elective periods at other hospitals, e.g. Fulbourn, Cambridge, Houston, Texas, etc.
10	St Thomas' ..	Visits to mental hospitals and nervous centre. Clinical clerking by students of OP and IP
11	University College Hospital	1. Occasional film strips or tape recording on case-taking of various syndromes. 2. Students act as 'Locum HPs'
12	Westminster ..	Visits and sometimes residence for a few days in mental hospital
13	Birmingham ..	Closed-circuit television and video-tape recordings
14	Bristol	Visits to local authority clinics, other hospitals, etc.

No.	*Hospital*	*Extra teaching methods used*
15	Oxford	Group-seminars in which both patients and students participate
16	Leeds	Visits to mental hospitals
17	Liverpool	
18	Manchester ..	Case-clerking in the university unit and visits to mental hospital
19	Newcastle ..	
20	Sheffield	Closed-circuit television for psychiatric interview
21	Cork	Few formal lectures are given: all lectures are of the 'topic' type and involve open discussion with active student participation. Students attend our early treatment unit over a period of at least three months. Teaching is mainly by discussion of cases or topics
22	Galway	
23	Trinity, Dublin ..	OP clinics in psychiatric OPs of general hospital. Resident students responsible for psychosomatic cases in wards. OPs under supervision
24	University College Dublin	Clinical teaching at psychiatric hospital in the psychoses. Clinical teaching in psychiatric department of general hospitals in psychoneuroses
25	Belfast	Combined teaching with department of therapeutics. General ward rounds. The department of mental health presenting patients in turn
26	Aberdeen	
27	Edinburgh ..	1. Throughout every term there are clinical demonstrations for senior students on Saturday mornings—alternatively psychiatry and neurology 2. Just acquired closed circuit television and video-tape and plan to use this for clinical demonstrations
28	Glasgow	Films followed by discussion. Interviewing patients on closed-circuit television or one-way screen, followed by discussion. Clinical clerkships in mental hospitals are available for elective
29	St Andrew's, Dundee	
30	Cardiff	

TABLE VII

Section (*e*)

No.	*Hospital*	*Examination in psychiatry?*	*Examiner*	*Method*
1	Charing Cross ..	Yes	Psychiatrist	Written
2	Guy's	Prize examination £30—First £20—Second	Psychiatrist	Written Oral Clinical
3	King's College ..	No, but prize examination for £10	—	—
4	London	Yes (1) Internal (2) In M.B. Final Med.	Physician	Written—Multiple choice
5	Middlesex ..	Yes, prize	Physician and Psychiatrist	— Written — Oral
6	Royal Free ..	Yes, in Final M.B.		
7	St Bartholomew's	Yes, in Final M.B.	Physician	Written Oral Clinical
8	St George's ..	Yes, prize	Psychiatrist	Oral
9	St Mary's ..	Yes, voluntary for prize	Psychiatrist	Written
10	St Thomas' ..	Yes, prize	Psychiatrist	Written Oral Clinical
11	University College Hospital	Yes	Psychiatrist	Written
12	Westminster ..	No	—	—
13	Birmingham ..	Yes, part of Final M.B.	Psychiatrist & Physician	Written Oral Clinical
14	Bristol	Yes	Psychiatrist	Written Oral
15	Oxford	Yes	Physician	Written
16	Leeds	Yes, 'optional sections'. Also prize examination	Physician & Psychiatrist	Written Clinical (a few cases only) Compulsory

No.	*Hospital*	*Examination in psychiatry?*	*Examiner*	*Method*
17	Liverpool ..	Yes	Psychiatrist	Written
18	Manchester ..	Yes	Psychiatrist	Written Oral
19	Newcastle ..	Yes, and prize examination	Psychiatrist	Written Oral Clinical
20	Sheffield	Prize examinations in psychology and psychiatry	Psychiatrist	Written Oral Clinical
21	Cork	Yes	Psychiatrist	Written Oral Clinical
22	Galway	Yes	Psychiatrist	Written Oral Clinical
23	Trinity, Dublin ..	Yes	Psychiatrist	Written
24	University College Dublin	Yes	Psychiatrist	Written Oral Clinical
25	Belfast	Yes, part of Final M.B.	Psychiatrist & Physician	Written Oral Clinical
26	Aberdeen ..	Yes, prize	Psychiatrist	Written Oral Clinical
27	Edinburgh ..	Yes, part of Final M.B.	Psychiatrist	Written Oral Clinical
28	Glasgow	Yes, part of degree examination which gives the Culten Medal plus two prizes	Psychiatrist	Written Oral Clinical
29	St Andrew's, Dundee	Yes, part of Final M.B.	Psychiatrist	Written Oral Clinical
30	Cardiff	Yes, part of Final M.B.	Psychiatrist	Written Oral starting in 1967

APPENDIX III

THE CONTENT OF EARLY POSTGRADUATE TRAINING FOR GENERAL PRACTICE IN PSYCHIATRY AND HUMAN RELATIONSHIPS

Basic subjects

Personality

Emotional, intellectual and psychosexual development in childhood, adolescence, adult life and old age
Personality types
Disorders of personality development
Defence mechanisms of the human mind
Emotions and bodily functions
Processes of conditioning and learning

Principles of social psychology

The doctor-patient relationship
The role of the patient in illness
Family relationships and psycho-dynamics
The family in psychiatric illness
The patient's view of psychiatric illness and treatment

Brain function in relation to psychiatry
Theoretical basis of treatment with psychotropic drugs
Theories of causation of psychiatric disorder

Techniques and responsibilities

Mental health promotion and the prevention of psychiatric disorders

Advice to the pregnant mother, to parents of infants, school children and adolescents
Sex education
Marriage guidance
The absent patient in the family
Anticipating the stressful events of life

Diagnosis

The consultation—moulding psychiatric history-taking and interview technique to this setting
Recognition of the physical expressions of emotional disorder
Recognition of psychiatric symptoms and syndromes
Eliciting the patient's current problems
Early diagnosis—especially of depression and suicidal intent

Treatment

Psychotherapy in general practice
Behavioural therapy
Altering the patient's environment
Psychotropic drugs and other physical treatments
Helping the relatives
The problem of the doctor's time

Communication

Referral to psychiatrists—indications, pitfalls, methods
Referral to other social and psychiatric services. The range of the relevant services. Definitions of words used in psychiatry

Medicolegal

The mental health act 1959
Admission to hospital
Confidentiality

Problems of human relationship and psychiatric disorders in the context of general practice

The range of problems which the general practitioner meets with commonly:

'Normal' life situations

Pregnancy and childbirth
The first baby
Mother-infant relations
Sibling rivalry
Starting school
Adolescence
Courting
Marriage
Unwanted pregnancy
Job dissatisfaction
Emotional aspects of physical illness
The climateric
Retirement
Bereavement
Fatal illness

Undifferentiated problems

Frequent attenders
Problem families
Sleep disturbance
Suicide and attempted suicide
Behaviour disorders in young children
Problems of schooling
The physical expressions of psychiatric disorders

Psychosomatic disorders
Emergencies
Trivial consultations
The hypochondriac
Polysymptomatic patients

Long-term personality disorder

Common types of vulnerable and immature personality
Sexual deviations
Impotence and frigidity

Neurosis

Anxiety states with or without physical symptoms
Phobic and obsessional states
Reactive depression

Psychoses

Manic-depressive disorder
Senile dementia
Schizophrenia
Organic psychoses

Other psychiatric disorders

Alcoholism
Addiction
Delinquency and criminal behaviour
Mental defect

Problems of relationship

Emotional and sexual problems in marriage
The child as an indication of family stress
The one-parent family
Problems in the doctor-patient relationship

APPENDIX IV

A SENIOR HOUSE OFFICER APPOINTMENT IN PSYCHIATRY IN THE BRISTOL ROYAL INFIRMARY, 1965

Staff

The professor
Another consultant
Senior lecturer
1 lecturer
1 medical assistant
1 registrar
2– senior house officers

Inpatient beds

In Princess Mary Ward and in Princess Elizabeth Ward, Bristol Homeopathic Hospital—staffed by sisters with mental nurse training—otherwise by normal general hospital staff in rotation.

Total beds: 18 female, 13 male.

TIMETABLE

	Morning	*Afternoon*
Monday	Registrar's 'round', clerking, etc., and psychotherapy for inpatients. Occasional visits to other parts of B.R.I. with professor or senior lecturer to see medical or surgical patients	Outpatients 2–5 p.m. (at least). (Mainly follow-ups)
Tuesday	9.30–11.30 a.m. ward 'round' informal discussion around table in library with all staff about all inpatients	ECT and ward duties
Wednesday	Free for study	Outpatients 2–5 p.m. (mainly new)
Thursday	As Monday	Free
Friday	9.30–11.30 a.m. ward 'round'	Cover for consultant's OPD and ward duties

During the day the senior house officers are on call for casualty. At night they take it in turn to be on call for the ward and casualty.

All types of mental disorder are admitted if beds are available—including addicts, alcohol withdrawal problems, etc. The unit has only had to transfer two patients in its three years' existence because of violence.

Senior house officers are involved in the teaching of medical students.