G.M.C. Conference on teaching sociology and psychology in basic medical education

J. D. E. KNOX, M.D., F.R.C.P.Ed., F.R.C.G.P.
Professor of General Practice, University of Dundee

Under the Chairmanship of Sir John Richardson, the General Medical Council convened a one-day conference on 26 February 1975 attended by 100 delegates mainly from medical schools in the United Kingdom. Sir John Brotherston, Chairman of the Medical Education Committee, reminded the conference of the 1967 recommendations of the General Medical Council urging medical schools to incorporate sociology and psychology into their curricula. Despite similar recommendations contained in the Todd Report 1968, medical schools had been relatively slow to respond. One of the aims of the conference was to encourage the exchange of ideas among teachers of behavioural sciences in a review of problems and progress of the teaching of this relatively new set of disciplines.

Professor Gwynne Jones

The case for teaching in psychology was made by Professor Gwynne Jones, of Leeds, who stressed the need to include experience as well as studies of behaviour. Attitudes of patients to doctors and to medical care as well as studies of the doctor were the concern of psychology in this context and attitudes of medical students might be moulded. Psychological science could be included in multidisciplinary courses having both a psycho-social and biological orientation.

Professor Illsley

Professor Illsley, Aberdeen, discussed the need to deepen and widen the doctor's understanding of relationships; this demanded knowledge of the socio-economic concepts, of the public's views of health and disease, of the place of medical care in perspective and of dynamics of care systems.

Sir Douglas Black

Sir Douglas Black, Chief Scientist, Department of Health and Social Security, concluded this session by suggesting that it was not now a question of " why teach psychology and sociology? " but of " how much and of what kind? " He felt the value of contributions from ethology to behavioural sciences in the medical course to be minimal and appealed for more teaching of the philosophy of science.

Discussion

Among the points raised in discussion were the implications of attempting to introduce new and unfamiliar disciplines and the lack of motivation of students; some support for the possible contribution ethology might make was voiced.

The conference went on to consider the content of teaching. Dr Humphrey, St George's Hospital, spoke on his paper, reviewing the present position in medical schools in the United Kingdom. He identified three broad approaches: methodological, human development, and interpersonal. Despite the claims by medical schools to be employing a " whole person " approach to medical education, his evidence suggested that the reverse was true and he cited an example of surgical teaching as a caricature of the disease-centred approach.

Dr Una MacLean

Dr Una MacLean, Edinburgh, reviewed current teaching of sociology and there was evidence of widespread activity in most schools (though Oxbridge appeared to be lagging behind). Yet Dr MacLean suggested that not enough support was being given to encourage future growth and there was evidence of active hostility to behavioural sciences in several schools.

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Professor Russell Davis

Professor Russell Davis, Bristol, went on to describe in detail the course in his medical school. This was based on the Department of Mental Health and appeared to depend heavily on lectures, though opportunities were provided for project work. Among several issues raised was the lack of an appropriate career structure in medical sociology and psychology.

Dr Millar Mair

Dr Millar Mair, Middlesex Hospital, discussed the Middlesex approach which aimed to interest and involve the student, to show the relevance of the scientific method to the disciplines and to convey information on specific topics. As part of the course, students were expected to interview, in their homes, people drawn from a random sample of the working population of London.

Discussion

During the discussion, the key question " where does the curriculum time come from? " was posed (but not answered!) and the point was made that behavioural sciences should not be planned and taught in isolation from the rest of the medical course—one speaker suggested that " behavioural medicine " was a more appropriate title which might help to minimise this danger. A strong plea was made to keep the subjects relevant to clinical medicine and to encourage motivation of the student to learn. The potential of general practice for this purpose was mentioned and Dundee had successfully blended a contribution from primary care with psychology and medical sociology.

Professor Kessel

Professor Kessel opened the final session, devoted to objectives and organisation, with his list of goals which were to provide an idea of the science that lies behind the disciplines and to provide " narrative material ". He appeared to reject what he termed the ' pretentionist ' goals involving humanistic and self-understanding approaches. While traditional sciences of anatomy and physiology were largely doctor-invented, behavioural sciences were not and this might account for some of the hostility to these new subjects.

Mr Nicoll

Mr Nicoll, National Union of Students, Health Students Committee Chairman, reviewed objectives against the background of overall goals of the medical course, and because attitudinal development was important small group teaching should be used. Unlike Professor Kessel, he felt that the aims should include efforts to strike an appropriate balance between ' scientific ' and ' humanising ' weighting and that the approach should be applied rather than basic science. He called for the setting up of an appropriate committee (possibly under the General Medical Council) to make firmer proposals about the implementation of courses in schools.

Professor Margot Jefferys

Professor Margot Jefferys, Bedford College, London, concluded this last session by discussing problems of the provision of sociological teaching (and teachers) in medical education. The lack of posts outside medicine to absorb the expanded output of sociologists in the 1960s had encouraged many to look for a career in medical sociology. Yet, developments in this sphere of medicine had not progressed greatly for several reasons, such as the relatively low priority medical faculties accorded such teaching, and the current economic difficulties.

The nature of the subject encouraged students to question accepted tenets and it could be regarded as a mark of success that its introduction was disturbing. While she advocated teaching by medically qualified staff, she felt that the education of doctors was not a matter solely for doctors. Professor Jefferys indicated the different orientations possible when medical sociology was based on different departments in medical schools; the result could cause some stresses within the developing disciplines of sociology.

Discussion

In discussion, the view was reiterated that medical sociology and related disciplines were not ends in themselves, but were introduced to assist future doctors in the delivery of health care and to deepen understanding of the diagnostic method and the management of people. A

student expressed the view that behavioural science courses did not appear to be well accepted because of problems with content, teaching methods, and the context in which the courses were taught.

Professor Crisp

Professor Crisp, St. George's Hospital, London, summarised the proceedings, stressing among other aspects the need to attract good teachers in courses of an appropriate mix, to develop an academic career structure, promote research, and integrate teaching vertically as well as horizontally in medical schools: this must entail collaboration with clinicians.

REFERENCE

Royal Commission on Medical Education (1968). Report. London: H.M.S.O.

INFANTILE GASTROENTERITIS

Between 3,500 and 6,000 cases of gastroenteritis in children under two years of age are reported each year in the United Kingdom from whom entero-pathogenic strains of *E.colli* are isolated. There is no tendency for this number to diminish. Yet this must represent only a minority of cases, as a recognisable pathogen is found in only 20–30 per cent of cases of gastroenteritis.

Indeed from the latest issue of the hospital enquiry for 1968 there seems to be a remarkably high number of children of nought to four years of age discharged from hospitals in England and Wales in the diagnostic group of ' diarrhoeal diseases.' In 1968 there were about 20,000 cases. This in turn can be but a small proportion of the total cases in the community.

REFERENCE

Gatherer, A. (1972). *Community Medicine*, **128**, 238.

EXTENSION OF FAMILY PLANNING SERVICE IN GENERAL PRACTICE

All general practitioners on the list of a single executive council were contacted and 91 per cent were interviewed. They were asked about the type of family planning currently provided and their willingness to extend the service. Only three per cent said that they were not providing any service at the time of interview, but only four per cent stated that they provided a complete range of techniques to all patients; almost two thirds of practitioners only provided advice and the Pill.

Lack of training in family planning techniques emerged as the most important factor in determining the type of service provided. At the time of interview, 64 per cent of doctors stated that they would like further training, and 35 per cent of all doctors asked for a full course of clinical training. Many general practitioners (81 per cent) were willing to extend their family planning services but 65 per cent wanted financial re-imbursement and 50 per cent needed additional administrative support as pre-requisites.

REFERENCE

Brennan, Mary E. & Opit, L. J. (1974). *British Medical Journal*, **3**, 30–33.