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THE UNDERGRADUATE TEACHING OF PSYCHIATRY
(based on a review of the situation in 31 medical colleges representing 10 countries in the Region)

by

Dr. Sabry Girgis*
WHO Temporary Adviser

This paper makes no claim at comprehensiveness. As its title denotes it is mainly concerned with a particular aspect of the training of the general practitioner for his work in the community. With this goal in view, the paper attempts at giving a picture, as clear as possible, of the position of psychiatry in undergraduate medical education as it stands at present in ten countries of the Eastern Mediterranean Region. It was aimed to achieve this through a questionnaire sent to 39 medical schools in the following countries: Afghanistan (2), Ethiopia (1), Iran (7), Iraq (3), Lebanon (2), Pakistan (11), Sudan (1), Syria (2), Tunisia (1), and United Arab Republic (7). Thirty three replies were received (almost 85%) [1]

It is obviously far beyond the scope of this paper to discuss whether or not the medical education of today is providing its graduates with the knowledge and training that would enable them to understand the health needs of the community and to perform their duties in this respect with efficiency, i.e. the diagnosis and treatment of the sick, the prevention

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[1] Two medical colleges (one in Iraq and one in Syria) replied that they do not as yet give their students any form of psychiatric instruction, because they are newly established. It would, therefore, be more appropriate for the purpose of our study to exclude them from the analysis, and work our analysis on replies as received from 31 medical colleges only.

* Consulting Psychiatrist, Cairo, UAR

of illness and the promotion of health; health in its broadest sense. Our main concern, therefore, is to verify what has lately been increasingly felt: that medical education is not providing the prospective practitioners with such psychiatric knowledge and training as will be adequate for the needs of their work in the community. One difficulty in this respect immediately emerges. There is no fixed measure, no generally approved standard of the content of the word "adequate" in this context. Consequently its meaning must naturally differ not only from one Region to another, but also within the same Region from one country to another. The reasons for this are not difficult to ascertain. In addition to the considerable differences in tradition, social structure and cultural background, there is also the obvious need that the level of psychiatric teaching in any country must keep pace with the level of medical education in that country, and this in turn has to be closely linked with the general level of development of the country, including, of course, the level of health services available at present or expected to be available in the not too far future. Nevertheless and not withstanding the inevitable existence of some such differences, a common working background can always be found, and in the light of common priorities in community health needs, a programme of psychiatric education, malleable to accommodate individual differences, can always be developed.

The questionnaire sent consisted of the following items:

1. a) How many hours of instruction are given to medical undergraduates in psychiatry, mental health or medical psychology which are taught by psychiatrists?
   b) In which years of the Course are they distributed?
   c) What are the teaching methods used: Lectures, discussions, practical work, or other means?
   d) Are examinations held in the subject: if so, how and when?
   e) Is there a detailed programme available?
   f) What is the name of the person in charge for the academic year 1969/70?

2. Is psychology taught separately; when and how much instruction is given, and is it taught by psychologists?

3. Is child development taught separately; when and how much instruction is given, and is it taught by pediatricians?

4. How are all these subjects integrated in the curriculum?

And now let us proceed to examine the replies received, and through a brief analysis of the information given try to find out what do they mean in terms of the position of psychiatry in undergraduate medical education in the countries concerned.

To start with how many of the medical schools that sent replies are giving some form of psychiatric instruction to their students, and in what years of the curriculum is this instruction given? The answer to these questions is shown in tables I and II.

TABLE I Number of Schools in which any kind of Psychiatric Teaching is given for the number of years shown (with reference to the various years of the curriculum)

Country	Years of Medical Curriculum					
	1st	2nd	3rd	4th	5th	6th
Afghanistan (2)	1	--	--	1	2	--
Ethiopia (1)	--	1	--	1	1	--
Iran (6)	3	2	1	2	3	4
Iraq (2)	--	2	--	--	2	1
Lebanon (2)	1	2	1	2	1	--
Pakistan (11)	--	1	1	6	11	--
Sudan (1)	--	--	1	1	—	1
Syria (1)	1	--	--	--	1	--
Tunisia (1)	--	--	--	--	1	--
UAR (4)	--	4	--	1	4	--
Total (31)	6	12	4	14	26	6

TABLE II Psychiatric Instruction as given along the different years of the Curriculum

Number of Colleges giving instruction during one year of the curriculum	6	20%
" " " " " " two years " "	15	48%
" " " " " " three " " "	8	26%
" " " " " " four " " "	2	6%
" " " " " " five " " "	--	--
" " " " " " six " " "	--	--
	31	100%

Analysis of tables I and II shows that all the 31 medical colleges are providing some sort of psychiatric teaching during one year or more of the curriculum. Six of them (20%) are limiting this instruction to one year only (one of them to the first year and the other five to the final year). Fifteen (48%) are giving psychiatric instruction during two years. Nine of these have one of the two years in the pre-clinical and the other year in the clinical period, while the remaining six give psychiatric instruction during two years of the clinical period. Of the eight (26%) colleges that extend psychiatric teaching over 3 years of the curriculum, one year falls in the pre-clinical and the other two years in the clinical period. Of the remaining two colleges (6%) that give instruction over 4 years, one gives one year in the pre-clinical and the other 3 years in the clinical period, while the other gives two years in the pre-clinical and two years in the clinical period.

As far as the "quantity" of instruction in terms of the number of hours given to medical undergraduates is concerned, the situation presents itself as follows:

TABLE III Mean Teaching Time

Country	Psychiatry			Behavioural Sciences		
	No. of schools providing information	Total hours	Average hours	No. of schools providing information	Total hours	Average hours
Afghanistan (2)	2	250	125	2	120	60
Ethiopia (1)	1	137	137	1	10	10
Iran (6)	6	759	126	4	130	32
Iraq (2)	2	152	76	2	30	15
Lebanon (2)	2	278	139	2	44	22
Pakistan (11)	11	178	16	5	56	11
Sudan (1)	1	232	232	1	25	25
Syria (1)	1	not shown		1	12	12
Tunisia (1)	1	35	35	1	25	25
UAR (4)	4	360	90	4	48	12
Total (31)	31			23		

Analysis of table III shows the wide variations in the average time allocated for the teaching of both psychiatry and the behavioural sciences. Regarding psychiatry all the 31 medical colleges are giving some form of instruction ranging in average between a minimum of 16 hours and a maximum of 232 hours. In one country the time is not shown, the reply being that psychiatry is given in the 5th year. As far as the behavioural sciences are concerned, although the variation in the average time allocated is still considerable, it is less marked than that for psychiatry, the minimum average time being 10 hours and the maximum 60 hours. Unlike the teaching of psychiatry 8 medical schools out of the total 31 do not include the behavioural sciences in the curriculum. Of the 23 schools that include behavioural sciences in the curriculum 20 give the course in the medical school itself, while 3 (one in one country and two in another) give this course in the Faculty of Arts and Science.

Regarding the teaching methods followed the situation is as follows:

TABLE IV Teaching Methods

Country	Lectures only	demonstrations only	Lectures and demonstrations	Lectures and Clinical Work	Lectures, demonstrations & cl.work	Lectures, demonstrations & clerkship
Afghanistan (2)	--	--	1	1	—	—
Ethiopia (1)	--	—	—	--	1	--
Iran (6)	--	--	2	—	4	--
Iraq (2)	--	--	1	--	1	--
Lebanon (2)	--	--	1	--	—	1
Pakistan (11)	3	1	7	--	--	--
Sudan (1)	--	--	—	--	1	—
Syria (1)	--	--	--	--	1	--
Tunisia (1)	—	--	--	--	1	--
UAR (1)	--	--	3	--	1	—
Total (31)	3	1	15	1	10	1

Analysis of the replies in table IV shows that the teaching method most commonly used is a combination of lectures and clinical demonstrations (15 colleges). The next in order of preference is the combination of lectures, demonstrations and clinical work done by students (10 colleges). In one of these, audio-visual aids are used in addition. In 3 colleges the method used is limited to lectures. In one the method is clinical demonstrations only. In another it is a combination of lectures and clinical work on the part of the student; and only in one is a period of clerkship introduced in addition to the lectures and clinical demonstrations. As far as the figures indicate patients are seen by students in 12 colleges (40%). If we add to these the colleges in which some sort of clinical work is used (e.g. clinical demonstrations) the figure rises to 28 colleges (90%). As in any other branch of medical science clinical demonstrations, important as they are, cannot substitute the skills gained by the students' first-hand contact with the patient. In any case, whether or not the time and content of the teaching are adequate for the purpose intended must remain a topic for further discussion in the Seminar.

The question of examination in psychiatry comes next. Tables V and VI show the method used, the time of examination and its relation with other subjects.

TABLE V Examination in Psychiatry with reference to method

Country	Method of Examination						
	Written	oral	clinical	combined	personal evaluation	not shown	no exam
Afghanistan (2)	--	--	--	1	--	1	--
Ethiopia (1)	--	--	--	--	--	1	--
Iran (6)	--	1	--	2	1	1	1
Iraq (2)	2	--	--	--	--	--	--
Lebanon (2)	1	--	--	1	--	--	--
Pakistan (11)	7	--	--	--	1	--	3
Sudan (1)	1	--	--	--	--	--	--
Syria (1)	1	--	--	--	--	--	--
Tunisia (1)	--	--	--	--	1	--	--
UAR (4)	--	--	--	1	--	1	2
Total (31)	12	1	--	5	3	4	6

TABLE VI Examination in Psychiatry with reference to time and relation with other subjects

Country	Time of Examination		no exam.	Relation with other subjects		
	end of course	during course		separate	with other subjects	not shown
Afghanistan (2)	2	--	--	1	--	1
Ethiopia (1)	1	--	--	--	--	1
Iran (6)	2	3	1	--	--	5
Iraq (2)	1	1	--	--	--	2
Lebanon (2)	2	--	--	--	1	1
Pakistan (11)	8	--	3	--	7	1
Sudan (1)	1	--	--	--	1	--
Syria (1)	1	--	--	--	--	1
Tunisia (1)	--	1	--	--	--	1
UAR (4)	2	--	2	--	1	1
Total (31)	20	5	6	1	10	14

Analysis of the method used in examinations in psychiatry shows that a written examination as the only means of assessing the students' achievements is held in 12 colleges out of 25 in which any form of assessment is made. In 5 colleges the method used is a combined one, i.e. any combination of written, oral and clinical. One college makes the assessment by oral examination, and in 3 others the assessment is made by an evaluation of the students' work during the training period. Four colleges, while admitting that an examination is held, do not show the method of examination followed. In the remaining 6 colleges no examination of any sort is held, and the students consequently pass unassessed.

Of the 25 colleges that hold examinations or assess their students by one means or another, 20 have this done at the end of the course, the remaining 5 colleges have this done some time during the school year.

Of the 12 colleges that hold a written examination in psychiatry, only one has the examination held separately. The vast majority, i.e. 10 colleges include

the examination in psychiatry with some other subject (9 with the paper of medicine and one with the paper of neurology). One college, however, did not show whether the written examination is held separately or included with some other subject. In 13 other colleges that make their assessment by some means other than a purely written examination, the replies do not show whether the assessment for psychiatry was made separately or in combination with another subject.

The replies to the question about whether a detailed programme was available is shown in the following table.

TABLE VII Programme

Country	Detailed	not detailed	not shown	no programme
Afghanistan (2)	2	--	--	--
Ethiopia (1)	1	--	--	--
Iran (6)	4	--	2	--
Iraq (2)	2	--	--	--
Lebanon (2)	1	--	--	1
Pakistan (11)	1	2	--	8
Sudan (1)	--	--	1	--
Syria (1)	--	1	--	--
Tunisia (1)	1	--	--	--
UAR (4)	2	1	1	--
Total (31)	14	4	4	9

Analysis of the replies about the programme shows that 14 colleges have a detailed programme, and some even enclosed the programme with the reply. There is a programme which is not detailed in 4 colleges. In 9 colleges there is no programme for psychiatric teaching. The remaining 4 colleges gave no reply on this point, and this can be safely taken as an indication that a programme is lacking. More important, however, than the availability or otherwise of a programme is whether the contents of the programme and the methods employed in training are such as to qualify the prospective doctor for his future work in the community. This is a matter of considerable importance, and should necessarily be left for further discussion.

As to the question about the name of the person in charge for the academic year 1969/70, the replies received reveal the following:

TABLE VIII Person in charge of the Teaching of Psychiatry

Country	Psychiatrist	Physician	Neurologist	not shown
Afghanistan (2)	--	--	--	2
Ethiopia (1)	1	--	--	--
Iran (6)	--	1	--	5
Iraq (2)	--	--	--	2
Lebanon (2)	2	--	--	--
Pakistan (11)	4	1	1	5
Sudan (1)	1	--	--	--
Syria (1)	1	--	--	--
Tunisia (1)	1	--	--	--
UAR (4)	2	--	1	1
Total (31)	12	2	2	15

Analysis of the replies about the person in charge of the teaching of psychiatry in the academic year 1969/70 shows that in 12 colleges the person in charge is a qualified psychiatrist with the academic post of professor or assistant professor. In 2 colleges the person in charge is a physician, or professor of medicine. The old link with neurology is still represented by the 2 schools in which the person in charge is a neurologist. The remaining 15 colleges give the name of the person without referring to his academic post. Some of these are presumably psychiatrists, and the lack of giving a definite status to the person can probably be attributed to the fact that it is taken for granted that he is a psychiatrist. In any case there still is a certain percentage of medical colleges in which the teaching of psychiatry is not yet the responsibility of a psychiatrist.

Then follows the question about whether psychology is taught separately, and if so, when and how much instruction is given, and is it taught by psychologists. The answer to these questions is shown in the following tables.

TABEL IX The Teaching of Psychology: How and When

Country	How Given			When Given		
	Separately	with other subjects	Not given	Pre-clinical	Clinical	not shown
Afghanistan (2)	1	--	1	1	--	--
Ethiopia (1)	1	--	--	1	--	--
Iran (6)	6	--	--	6	--	--
Iraq (2)	2	--	--	2	--	--
Lebanon (2)	2	--	--	2	--	--
Pakistan (11)	5	2	4	4	2	1
Sudan (1)	--	1	--	--	1	--
Syria (1)	1	--	--	1	--	--
Tunisia (1)	1	--	--	--	1	--
UAR (4)	4	--	--	4	--	--
Total (31)	23	3	5	21	4	1

TABLE X Teaching of Psychology: by Whom?

Country	by Psychologist	by psychiatrist	by physician	not shown	no teaching
Afghanistan(2)	1	--	--	--	1
Ethiopia (1)	--	1	--	--	--
Iran (6)	4	2	--	--	--
Iraq (2)	--	2	--	--	--
Lebanon (2)	1	1	--	--	--
Pakistan (11)	2	2	1	2	4
Sudan (1)	--	1	--	--	--
Syria (1)	1	--	--	1	--
Tunisia (1)	--	--	--	--	--
UAR (4)	--	3	--	1	--
Total (31)	9	12	1	4	5

Analysis of the information given in answer to the questions about the teaching of psychology shows that psychology is taught in 26 out of the 31 colleges included in the investigation; no teaching being given in the remaining 5. In 23 colleges it is taught separately; in 2 it is taught with medicine and in one it is taught with psychiatry.

In 21 colleges psychology was given in the pre-clinical period (in 3 colleges of these (2 in Iran and one in Lebanon) it is given in the pre-medical period. In 4 colleges it is given in the clinical period (3 in the early clinical and one in the late clinical period); and in one college answer does not show when it is taught.

As to who teaches psychology the answers show that only in 9 colleges is it taught by a psychologist, while in 12 the teaching is undertaken by a psychiatrist. In one the teaching was given by a physician, and in the remaining 4 the person responsible for the teaching was not shown.

The teaching of child development is shown in the following tables:

TABLE XI The Teaching of Child Development: How and When

Country	How					How much		When	
	separately	with pediatrics	with psychiatry	with psychology	not given	in hours	not shown	period	not shown
Afghanistan (2)	1	1	--	--	--	--	2	2 cl.p.	--
Ethiopia (1)	--	1	--	--	--	--	1	1 cl.p.	--
Iran (6)	--	2	1	--	3	--	6	3 cl.p.	--
Iraq (2)	1	1	--	--	--	8	1	1 cl.p.	1
Lebanon (2)	--	--	--	2	--	--	2	2 pre-cl	--
Pakistan (11)	7	2	1	--	1	2/30/30	7	10 cl.p.	--
Sudan (1)	--	--	1	--	--	--	--	1 cl.p.	--
Syria (1)	1	--	--	--	--	--	--	1 early cl.	--
Tunisia (1)	--	1	--	--	--	--	--	1 early cl.	--
UAR (4)	--	--	1	3	--	3	3	3 pre cl 1 cl.p.	--
Total (31)	10	8	4	5	4	5	22	26	1

TABLE XII The Teaching of Child Development: by Whom?

Country	by pediatrician	by psychiatrist	not shown	not given
Afghanistan (2)	2	--	--	--
Ethiopia (1)	1	--	--	--
Iran (6)	2	1	--	3
Iraq (2)	1	--	1	--
Lebanon (2)	--	2	--	--
Pakistan (11)	9	1	--	1
Sudan (1)	--	1	--	--
Syria (1)	1	--	--	--
Tunisia (1)	--	--	1	--
UAR (4)	1	2	1	--
Total (31)	17	7	3	4

Analysis of the information given in answer to the question about child development shows that although the number of faculties that give some sort of teaching in child development is 27, the teaching of this subject does not seem to be sufficiently established, nor its importance sufficiently recognised. This is particularly reflected in the number of hours devoted to the teaching of this subject. In 22 of the 27 faculties that gave some teaching no mention was made of the hours devoted for this purpose. In the 5 faculties that did mention the time, the hours are as follows: 2 hours in one; 3 in another; 8 in a third, and 30 hours in the remaining 2 schools. Apart from the number of hours, in 10 faculties the answers show that it is taught separately; in 8 it is taught with pediatrics; in 4 it is taught with psychiatry; in 5 it is taught with psychology, and in the remaining 4 it is not taught. In 22 out of the 26 faculties the teaching took place at some time during the clinical period (in 20 in the late clinical, and in 2 in the early clinical period). In 4 it took place in the pre-clinical period, and in one the time was not shown.

Of the 26 faculties, the person responsible for the teaching is the pediatrician in 17, the psychiatrist in 7; and in 3 faculties the person was left undefined. On casting a more careful look on the figures related to the teaching of child development it becomes clear that the replies do not reflect a stable relation between "the how", "the when" and "the by whom" aspects of the teaching of this subject.

Coming to the last question, that about how are all these subjects integrated in the curriculum, the answers do not seem to give a clear view of the situation in this respect. This state of affairs is reflected in the fact that 7 faculties gave no answer at all; 2 others stated clearly that there was no integration; 4 more answered in the affirmative, but did not show how the integration is taking place. In the 18 faculties where some explanation was given, the explanation was expressed in such statements as "during consultative work", "in combined clinical meetings, panel discussions, conferences and seminars","integrated with the whole course", "integrated with internal medicine", "with pediatrics", "with neurology", "well integrated in curriculum and culture", "as part of curriculum", "integrated with appropriate subjects in syllabus", etc. Does this lack of clarity denote that in many countries psychiatry has not yet gained its independence as a medical speciality and that it is not yet sufficiently differentiated from some of the other medical disciplines? In any case there seems no contradiction between psychiatry as being an independent and a differentiated medical speciality and its being well integrated in the medical curriculum. On the contrary, experience has shown that this combined differentiation and integration has always been an enrichening factor for both psychiatry and general medicine.

I believe there is near to unanimous agreement on the enormous discrepancy between the need for psychiatric care and the competence of the general practitioner and the community doctor to meet this need. Likewise I believe also that there is a similar agreement on the fact that this problem cannot be solved by the provision of specialist psychiatrists alone. The solution, therefore, can only be achieved by providing the general practitioner and community doctor with sufficient psychiatric knowledge and training as would enable them to cope with as many as possible of the psychiatric cases in

their every-day practice. It follows naturally that the undergraduate teaching of psychiatry should be geared towards this end.

The duties of the community doctor, to a great extent, obviously depend, among many other things, upon the morbidity pattern prevalent in the community, on the health services available, on the level and extent of health awareness of the people, and on the social structure of the community with its set of traditions, social habits and customs and cultural background. This entails that in the practice of medicine to-day it is not any longer possible to consider the individual apart from his environment and from his culture. Needless to say, there are wide variations between different countries in this respect; indeed also between subgroups in the same country.

Bearing in mind the state of rapid socio-economic development which most countries are undergoing at present, and the stresses that inevitably accompany changes in the socio-economic structure of the community, an increasing incidence of mental ill-health is expected. Probably the increase will not affect the major forms of mental illness, i.e. the psychoses, as much as it affects its milder forms i.e. the psychonemoses and psychosomatic disorders. It becomes, therefore, a vital health need that in the training of the prospective general practitioner and community doctor, sufficient psychiatric and mental health principles should be included as to properly qualify them to perform their tasks in the treatment of illness and in the promotion of health. This becomes even more important when we remember that in many countries and probably also for many years to come the general practitioner and the community doctor are often the only medical aid available to the majority of the population, or at least the first line of medical aid for quite some time before the patient can be referred to more specialised help.

What psychiatric and mental health tasks, therefore, are the general practitioner and the community doctor expected to perform in their every day work, and what skills should they possess for the efficient undertaking of these tasks? In other words, what should be the objectives of the undergraduate teaching of psychiatry?

In answering this question no originality is claimed since this topic has been subject to repeated discussions in Regional Seminars, WHO Expert Committee meetings and Public Health papers.

At the start it seems essential to emphasize the fact that hardly any objective in the field of psychiatry can be achieved without accepting as a basis the dynamic concept of the human personality with all its implications on human behaviour and personality development. This, of course, entails good knowledge of personality development and the structure and function of personality. If this dynamic concept of personality is accepted the introduction of the interview and the acquisition of skill in interview techniques should necessarily be an essential preliminary for all diagnostic and therapeutic work. Within this dynamic framework due consideration will be given to the physical, psychological and social aspects of the patient's life in general and of his presenting symptoms in particular.

What, then, are the specific tasks which the general pratitioner and the community doctor are expected to perform in their every day practice? These tasks may be briefly mentioned under the following broad headings:

1) Dealing with psychiatric emergencies.
2) Recognising psychiatric disorder in its different forms, subtle and gross, and whether it presents itself in physical, psychological or social symptoms, and judging correctly which of its forms he can deal with and which have to be referred to more specialised care. In this respect he should be able to deal with many of the major psychiatric illness and to manage the minor psychiatric disorders prevalent in general medical practice.
3) Assessing fairly accurately the role of psychological and social factors contributing to physical illness, and possessing the ability to manipulate such factors as part of the total therapeutic procedure.
4) Understanding cultural factors influencing the life of people and shaping their disease pattern, and utilising this understanding in therapeutic and preventive work within the frame of the particular culture. This means that one of the aims of psychiatric teaching

of the general practitioner and community doctor would be to increase their social awareness and to build up socially responsible attitudes.

5) Using with skill the psychiatric treatment methods appropriate to the cases he is dealing with, including the physical, psychological and social methods.

6) Acting, through effective interpersonal relationships, as health educator, studying the different factors that detrimentally influence the health of the people. Worthy of special mention in this respect is the study of prevalent superstitions, prejudices and local habits, and collaborating with other professional personnel and local leaders in correcting, in a very subtle way, unhealthy habits and attitudes. This entails the ability to work cooperatively and constructively with a team.

If these tasks perhaps with some modification here and there, are accepted as constituting an integral part of the work of the general practitioner and community doctor, it follows almost automatically that these should also be the objectives of the undergraduate teaching of psychiatry. If so, we are immediately faced with the question: does the undergraduate training in psychiatry at present, as revealed by the replies to the questionnaire, qualify the prospective general practitioner and community doctor for their future work? Does this training help them to meet the demands and needs of every day practice? Does it even inspire them with respect to psychiatry as a medical science, and does it help them to develop the conviction that as such it can enrich their knowledge, broaden and deepen their scientific and human outlook and guide them to help others in a better and more effective way? In brief, is the present state of undergraduate psychiatric teaching adequate in quality and in quantity?

If the answer to these and similar other questions is, as I think we shall all agree, in the negative, the logical question that inevitably follows is: can anything be done, and what is it?

This paper does not intend to give any direct propositions in answer to this last question. Rather than that it will try to raise a number of

questions, the discussion of which will, it is hoped, constitute the basis for whatever means are found necessary and possible to implement in terms of advancing the undergraduate teaching of psychiatry.

To start with, is the amount of psychiatric teaching, as it is provided now, adequate; and is it effectively distributed over the years of the curriculum? Is the time allocated for it proportionate with its importance on the one hand, and with the time allocated for other subjects in the curriculum on the other hand? Are the topics given what should really be given, and are their contents adequate for future general and community practice? Are behavioural sciences considered really necessary as a preliminary pre-requisite for later training in psychiatry? Are they really valued for the knowledge and understanding they can provide: knowledge about norms in society, i.e. about normal individual behaviour in a given culture, and knowledge about the existence and role of social institution and how can they be best utilized? If so, and in an already overcrowded curriculum, what and how much of the behavioural sciences should be given priority: psychology, social psychology, sociology and/or anthropology? When, during the years of the curriculum, should they best be given, and where: in or outside the medical faculty? Who will teach them: social scientists, clinical psychologists or some member on the staff of the medical faculty, and who: a psychiatrist, a physiologist, a paediatrician or a member from the department of preventive medicine? How should these subjects be taught: separately or in relation with some other medical subject, e.g. physiology, or both? And last how can their content be made meaningful to medical students; in other words how can medical students be made convinced of their practical medical significance?

Turning to psychiatry, is the time allocated for training in psychiatry adequate, and what should be the contents of the syllabus in relation to the years of the curriculum? Are the teaching methods followed the best in terms of achieving the aims of training, and if not where is the defect and how can it be remedied? Can clinical skills in psychiatry be acquired without direct contact between student and patient during interview and examination techniques, i.e. is examination of patients by students necessary for the acquisition of appropriate skills? Can such skills be obtained

without a term of clerkship, and if not, when such a term be given and for how long? Are the contents of the syllabus relevant to everyday medical practice? Are the available teaching facilities adequate for the purposes of good instruction, and are the present facilities used to their maximum? Does psychiatry have a legitimate place in the curriculum as an independent discipline, and is there an independent department of psychiatry? Are psychiatric departments in medical schools, if there are any, sufficient, with their staff and their in-patient and out-patient services, for the purposes of good teaching, or is it necessary to collaborate with a psychiatric hospital; and if so, what is the role of the psychiatric hospital in the teaching of psychiatry? Is a separate examination in psychiatry necessary, and if so, what is the method of examination and when should it be held? Are psychiatry and allied subjects integrated in the medical curriculum, and to what extent? Is integrated teaching always and unreservedly an advantage, or does it include the possible risk of hampering the growth of individual disciplines? If so, what measures should be followed to obtain the advantages of integration without its possible disadvantages? And last but not least, is the time now ripe to raise psychiatry in undergraduate medical education from the status of a "minor" to the status of a "major" subject; and within available facilities, how can this be effected? What possible measures should be taken to eliminate the social stigma attached to psychiatric illness and the scientific stigma attached to psychiatry itself, attributing to it such qualities as "vague", "unscientific" or even "non-medical"? In brief, how can we, as has been quite rightly stated, turn the objective of psychiatric education, as indeed it is the objective of all education, from the mere acquisition of knowledge, to the ability and power to use it?

And once again this paper makes no claim at covering all the points pertaining to the undergraduate teaching of psychiatry. But if in this respect it had managed to raise some questions and to stimulate some others for discussion, it will have more than fulfilled its purpose.