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WHY TO TEACH PSYCHIATRY TO MEDICAL
STUDENT AND HOW TO TEACH IT

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In recent years medical schools get more and more concerned regarding the teaching of psychiatry to their students.

Numerous articles published all over the world put stress on the important role that psychiatry and psychology should play in medicine and medical education in general. We cannot possibly review here all the literature on the subject, and shall only limit ourselves to pointing out the salient facts transpiring from these :

1. An urgent need for radical changes in the medical curriculum is felt by all in the sense that psychiatry should be given a more prominent place it rightly deserves;
2. no unanimous agreement, however, has been reached at, as to its place in the curriculum; and
3. most important of all, little has been said about the purposes these changes are to serve.

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It therefore seems to us that before tackling the question of the ways of teaching, it should first be clearly defined what this teaching aims at. Once this point is clarified, there should be no difficulty at reaching at a general agreement as to the place of psychiatry in medical education, and the methods of teaching.

Psychiatry in medical practice

To elicitate the role of psychiatry in daily practice, it will be appropriate to see the variations of frequency and morbidity rate of psychiatric illnesses obtained in general practice and to compare them with those obtained in a field survey.

A nice illustration of this is to be found in a study by Martin and co-workers (1957) :

In this study of neuroses the prevalence rate is given as 350 per thousand at risk in a house-to-house survey, while the figure obtained from medically diagnosed psychiatric illnesses in the same area is only 62.3 per thousand at risk.

More recently Shepherd and co-workers (1966), in their detailed work on psychiatric illnesses in general practice show a considerable interpractice variation in the reported prevalence rate of psychiatric illness in 12 practices. The highest figure is 323.3 per thousand and the lowest 37.8 per thousand at risk. Although they give evidences of some real variation, ascribing it to demographic and social characteristics of the population at risk, however they succeed in demonstrating that the variation must be largely ascribed to differences between doctors rather than between practice-population.

Variations exist as well in figures of different prevalence surveys. Understandingly enough, they are largely due to the different diagnostic criteria, methods and scales of survey used, and also to ecological differences of population. Probably the highest figure, as Shepherd (1966) has pointed out, is that of Midtown Manhattan Study - 230 per thousand, and the lowest figure, provided by Lamkau - 60.5 per thousand in the Eastern Health District of Baltimore.

However, when we compare the above figures, we find that the range of the reported rates in general practice is very much wider than in the survey group, the first being about nine-fold and the second about three-fold. Thus the importance of doctors' attitude in recognizing minor cases of psychiatric illnesses becomes evident.

Psychiatric illnesses in general hospitals

Studies carried out in general hospitals show a rather high psychiatric morbidity rate.

Granville-Grossman (1967) made a survey of the incidence and type of psychiatric morbidity among the patients admitted to a unit of 32 medical beds at St. Bartholomew's Hospital. During a period of five months there were 172 admissions: out of these 172, eight (4.6%) were found to be suffering from formal psychiatric disorders. Another 4.6% of the total admission comprised eight patients suffering both from organic and mental illnesses. Thus in 16 out of the 172 patients - that is to say over 9% - the psychiatric state appeared to be of importance, but they admit that this figure is almost certainly a great underestimation of the total psychiatric morbidity, as minor psychiatric cases are not included.

Lunn (1963) made a survey of the incidence of psychiatric illnesses on 2594 patients admitted to medical wards and estimated psychiatric cases (450 patients) at 17%. The corresponding figure for the surgical wards was of 6% (183 out of 3315 admitted patients).

A survey made in Iran (Eshghi and Davidian, 1967) on 180 patients admitted to medical wards, revealed a 10% incidence of psychiatric illnesses. These had been admitted because of severe physical complaints and symptoms, although they were suffering from formal psychiatric disorders, mainly from depression and anxiety. In another 35% of the above total, abnormal psychiatric conditions were present either in association with physical illnesses, or in the form of well-defined psychosomatic conditions.

A similar study (Bazergan and Davidian, 1966) has been carried out in the cancer ward on 75 patients. 45 of them were suffering from a variety of cancers and 30 were either admitted for further investigation, or had undergone surgical interventions, other than cancer. This study was particularly planned to investigate the incidence of effective disorders in patients suffering from cancer. The findings revealed that 29 patients (60% of cancer group and 16 (59.2%) of the other group were suffering from a variety of depressive and anxiety states. It is worth mentioning that eleven patients (9 from the cancer group) had severe depression.

Psychiatric illnesses in out-patient clinics

Comparatively more studies have been carried out on psychiatric problems in out-patient clinics. Taylor (1969) studied 336 medical patients in Victoria Infirmary out-patient clinic, Glasgow. Of this

total 98 (29.4%) suffered from some kind of psychiatric illness, of which 34 (34.6%) had been diagnosed by general practitioners. Taylor reviews a series of well-known studies by Logan & Cushion (1958), Kessell (1960), Fry (1960), Kellner (1963) and Shepherd & co-workers (1964) in general practice, who give incidences varying from 4 to 12%; further he gives figures obtained by Davies (1964) who found an average of 27.3% in eleven different surveys: Brodman & co-workers (1952) who give an incidence rate of 30% and Maclay (1965) - 26%.

It is important to note that in all of these studies the figures refer to purely psychological cases and exclude combinations of organic and psychological diagnoses in the same patient.

A study made in Iran (Davidian) on psychiatric referrals during a period of 12 months shows that out of 1110 new adult psychiatric patients who attended the clinic for the first time, 908 (81.6%) had previously been to an internist or some specialist other than a psychiatrist. Of these 908 patients 711 (78.3%) had been to internists in their first consultation.

As patients in Iran have free access to any doctor, the high rate of 78.3% is an indication of their preference for internists. Statistical analysis show that the least probable reason for this preference is the shortage of specialists and psychiatrists. The reason given by patients for consulting an internist largely turns around the predominance of somatic symptoms or the fact that they attribute their mental ill health to some physical disorder. Of the 1110 patients 786 (70.8%) had predominantly somatic symptoms and complaints.

Similar situations have been shown by many workers in surgical clinics and in other specialties: for example Bryson (1945) found out an incidence of about 7% of psychiatric illnesses in surgical clinics.

Thurston (1969) studied 260 patients admitted consecutively with a diagnosis of acute myocardial infarction to the Westminster Hospital Coronary Unit, and found a rate of 20% of "misdiagnoses". Although he does not mention the underlying etiology of the "misdiagnosed" group, it is not difficult to guess that a great majority of this kind of patients may be suffering from psychological problems.

Culpan & co-workers (1960) found a prevalence rate of emotional problems in 50% of patients in gynaecological clinics. Barker (1968), using statistical analysis in a study on the incidence of psychiatric illnesses after hysterectomy, confirms the occurrence of higher incidence of psychiatric illnesses in such cases, as previously stated by many authors.

Association of physical and psychiatric illnesses

The high rate of physical illness in psychiatric patients is a point that deserves attention.

Cooper (1965) in his studies on 95 chronic psychiatric patients found that nearly half of them had some associated chronic physical illness. Kurland and Hammer (1968) found out that in addition to the fact that neurotic patients do become physically ill, the stress of physical illness and of pain and discomfort are related to behaviour patterns typically described as neurotic.

The causal relationship between physical and psychiatric illness is not yet fully understood. Although Shepherd & co-workers (1966) found that emotional disorder is related to high demand for medical care in patients, they state that "to what extent psychological factors constitute a principal or major determinant of illness-proneness cannot yet be assessed".

Similarly, while Kreitman and co-workers (1966) found positive association between psychosomatic illness, minor organic illness and symptomatic complaints, they cannot confirm Hinckle & Wolf's (1957) general theory of illness-proneness to the effect that those who exhibit greater susceptibility to mental illnesses exhibit as well a greater susceptibility to all forms of illnesses.

But what is important to us is the fact that psychological and physical ill-health is often to be found in close association in one person, and we might not be far from truth if we do not look for a causal relationship between these two conditions, for they may be considered as a general disordered biological condition.

Emotional stress and physical illnesses

The studies mentioned below are other examples of the relation of physical and psychological factors in causing physical diseases. These concern some of the major physical illnesses.

A. Siegler (1967) found that repeated psychic trauma, in emotionally disturbed individuals, cause cumulative psychologic effects which gradually help to induce structural alterations in the cardio-vascular system, thus becoming an underlying cause in the pathogenesis of atherosclerotic heart disease and in inducing an acute cardiac insult.

A. Whitaker (1969), reviewing the current views on the etiology of coronary heart disease, points out that although the deaths resulting from coronary artery disease are increasing, most authorities believe that there has been no serious increase in the incidence of coronary arteriosclerosis and that the new feature is a more common occurrence of coronary thrombosis, with the development of a cardiac infarction and its complications.

J.N. Morris carried out a retrospective survey of necropsies over several decades and concluded that whilst occlusions, thromboses and active infarcts had increased, there was no evidence of any more severe coronary atheroma than in 1914. He discusses the factors predisposing to atherosclerosis and those precipitating thrombosis and concludes that at present cardiac infarction has to be accepted as the result of the interplay of many factors, and gives an important place to environmental conditions. Among psychological factors he mentions Friedman's and his colleagues' work on the relationship between personality and coronary artery disease where they recognize two personality types among patients suffering from these diseases. The mortality rate is given as six times higher in those categorized by them as type A: a driving, competitive, restless, alert, impatient, ambitious person with preoccupations for job deadlines. At the end he agrees with the general view that in clinical practice psychological and emotional stress is often an important precipitating factor.

Cash (1967) and many other workers believe that acute and/or prolonged mental stress may bring about coagulation-fibrinolysis disequilibrium in some.

In 1943 Wolf and Wolf demonstrated on Tom with a gastric fistula that remarkable changes occur in the mucosa of the stomach under the influence of mental perturbation.

Many authors have made investigations on the relationship between psychological factors and the development of peptic ulcer. Without mentioning their works, we will quote the view expressed by the British Medical Journal (1969): "Personality factors or emotional status may determine chronicity of the ulcer or modify the patient's response to treatment".

It is of significance to mention Johnston's & co-workers' (1967) findings that more than 5% of those operated upon had a disastrous outcome. These patients were recognized in retrospect as associated with pre-existing personality defect. They note that surgeons warn their patients regarding the abuse of aspirin and alcohol before the operation for intractable peptic ulcer, but are perhaps reluctant to use psychological tests in predicting the outcome.

Daily observations of many doctors show that stress and strain very often precede perforation or haematemesis.

Jenings (1968) found that of a total of 338 haematemesses, 139 gave a history of preceding nervous strain.

The works of David Kissen (1958, 1962) on lung cancer and his description of their personality as "poor outlets for emotional discharge" are well known. He also found in a controlled study that 41% of lung cancer group had had an important adverse emotional experience in childhood and 60% of them had had one in adult life. The corresponding figures for control group were of 20% and 18%. In another study he stated that

adenocarcinomas, on the whole, tend to be associated with a greater proportion of peptic ulcer and psychosomatic disorders than do the other histological types of lung cancer.

Green (1966) found that separation and loss present a setting where often leukemias and lymphomas develop.

Solomon (1969) puts forward experimental evidence that some forms of stress may reduce primary and secondary antibody response in rats and that adult immunologic responsivity may be altered by early infantile experience: "Stress and emotional distress may influence the function of the immunologic system. Thus, environmental and psychological factors might in some circumstances be implicated in the pathogenesis of cancer, the resistance to which growing evidence finds immunologic in nature, as well as of infections and of autoimmune diseases which seem to have an association with states of relative immunologic incompetence".

Katz & co-workers (1969) have found that psychological co-variants of hydrocortisone production rates do exist in women with breast tumours. The potential consequent influence of this finding on the prognostic Bulbrooks corticosteroid-androgen ratio appears to raise significant questions about the possible effects of psychological variables on the course of cancer of the breast.

Since the pioneer work of Selye (1936), who illustrated the prominent role of the adrenal cortex in the endocrine response to stress, numerous works have been carried out demonstrating an increased production of corticosteroids occurring under stress.

Now it is well known that a wide variety of stressful situations provoke increased secretion of cortisol by the adrenal cortex in response to adrenocorticotrophic hormone released by the anterior pituitary. This has proved

true even under the hypnotic suggestion of fear and anxiety (Black and Friedman, 1968). They also have shown that the plasma cortison levels of any individual hospital patient varies at the same hour on different days. This suggests that the mental state of the patient must be taken into account in any assessment of adrenal function by this means. The plasma cortisol levels were found to be higher during the first few days after admission to hospital than they were afterwards, and the levels were highest in those patients who appeared to be most anxious as a result of their admission.

Furthermore, Bourne & co-workers (1968) have demonstrated that 24 hours urine 17-hydroxycorticosteroid levels varies in different individuals according to the different behaviour expected from them in a similar stressful situation.

It would be superfluous to talk about all other ~~responses~~ responses to stressful situations which involve thyroid gland, sex hormones, autonomic nervous system etc. producing transient or permanent modifications in body.

Psychiatric consequences of physical illnesses

Minor and major psychiatric reactions in the course of a physical illness, or following it, are well known phenomena. But even a greater number of patients are affected by emotional reactions created by socio-economic perturbances and other ill-effects that may be brought about by the illness.

Similarly there is no need to discuss such conditions as emotional reactions of chronically ill persons and the disabled, the anxieties of expectant women or the ill-effect of long hospitalization on the mental health of young children. We would like, however, to mention the psychological problems arising in patients who are the beneficiaries of the recent developments in medicine. To quote Cramond and co-workers (1968): "Patients

by chronic renal failure who would have died can now be maintained by recurrent hoemodialyses or by renal homotransplantation. These new developments have thrown up new problems of management, psychological problems being one of them".

Psychological problems arise not only in the patient but they develop in the donors and the medical team as well. These problems comprise a wide variety of different psychiatric reactions which necessitate psychiatrist's intervention. (Kaplan et al, 1968; Goody & Kelly, 1967; Menzies & Stewart, 1968; B.M.J. 1968). Same is true of patients treated with cardiac pacemakers (Crisp & Stonehell, 1969).

The ever-increasing measures of birth control, such as sterilization of women (Thompson & Baird, 1968) and the use of oral contraceptives (Grant & Pries-Davies, 1968; Lewis & Moghugh, 1969) bring about psychiatric complications with which one comes across more and more.

Another important problem in everyday practice is the deprivation and segregation of patients. Recent studies come to confirm once more their ill-effect and reveal that more often than not it could be dispensed with, by providing the patients with warmer homely entourage and thus lessening the incidence of emotional problems and physical complications. These studies have been carried out on tuberculous patients, myocardial infarctions, as well as on the possibility of domiciliary confinements and early discharge of maternity patients from hospitals, permitting children to visit their sick mother in hospitals and letting the mother stay with her ailing child in the hospital. (B.M.J. 1967; Sleet 1968; Alment et al 1967; Arthurton & Bamford 1967; Craig and Muirhead 1967; B.M.J. 1968; Brain & Maclay 1968).

Man as a psychobiological whole

The role of physical and psychological factors in health and in disease, the close relationship between physical and psychological factors in having impact on the determination or predisposition, causation, course, prognosis and on the outcome of management of any given illness come to prove that MAN, healthy or sick, could be looked upon as a unity, an integrated whole and unseparable into body and mind. Although this concept has received acceptance almost universally, it is not yet being fully applied in practice and has not gained its proper place in medical teaching.

The outstanding achievements in medicine in the last decade come to modify the concept of medicine by offering it an over-all psycho-somatic concept. As Leigh (1968) puts it: "... psychosomatic medicine is synonymous with medicine if in the system of medicine is included the total assessment of the sick person, his psychology, his personality, his social relations, as well as his physical structure and function". And Martin (1967) rightly remarks: "We very often forget to show this aspect of medicine to medical students, and consequently he loses sight of the patient as a 'whole person'".

Simultaneous teaching of psychological aspects of diseases, while teaching them clinically and theoretically would be the ideal way to create the concept of seeing the patient as a WHOLE. This should be the main purpose for teaching psychiatry to medical students.

Another practical reason for teaching psychiatry is the training of the future doctor to be prepared to face and treat the bulk of psychiatric patients who will attend any clinic at any time. In many instances, and specially in those countries where patients have free access to any doctor, any specialist may be largely involved in general practice. So specialists,

together with family doctors, have to carry the main burden of minor psychiatric cases, while, as May & Gregory (1968) state, "most of them have neither inclination nor preparedness to handle such patients". These handicaps cannot be attributed to anything else but to the backwardness of medical education as compared to rapidly developing new concepts in medicine, revealed by psychiatry. And as Humphrey (1968) suggests, "nothing short of radical changes in the medical curriculum will ameliorate this condition". Moreover, it is not only the medical curriculum that needs to be changed, but also teachers' attitude towards psychiatry, giving it more place in their daily work and teaching.

Community Medicine

The term "community medicine" has been coined recently and is now largely used. It is that aspect of medicine where the healthy and the sick are of equal importance. Among other functions it concerns itself with "broad questions of health and disease in the community at large". (Royal com. on med. educ. 1968). It includes the management of all illnesses, whether curable or not, and as Vickers (1967) states: "management is more than therapy: it means relief of suffering, aid in living with disability, whether transient or permanent, limitation of disturbance in all the social systems which an illness disturbs". Its field of function is not only restricted to hospitals and individual patients: its activities are largely expanded into the community, trying to bring relief, to manage and prevent illness in the community.

Although community medicine has become a speciality in Todd's report, it can be considered as a concept and a type of approach as well, where man is looked upon as a person in close relation to his environment, as a psychological and psychosocial whole.

In this respect psychiatry is far better advanced, for when dealing with a patient, it considers him not as a pathological sample but as an individual - social by nature, and living in a certain social setting - with inherited and acquired personality traits: as somebody who thinks, feels and reacts: as an individual tied up to his past experiences and his present environment: as a sick person the causes of whose illness should be searched not only inside his body but also in his past history and present living conditions; and where treatment and prevention of illness are both directed towards man and his environment.

Although the aims of psychiatry and community medicine might not be the same, but as we have already seen, the working methods of both present great similarities. Consequently, when learning psychiatry, we have to learn its working methods, which can thereafter be easily applied to community medicine.

Prevention of illnesses gains more and more importance, and as Knowles (1969) points out "the health of a community must inevitably include considerations of its economic, educational, recreational, housing and general social conditions inevitably medicine must concern itself with larger fields of social welfare and develop a holistic concept of a community's health, if it is to prevent disease and maintain health and thereby enhance the quality of life and contribute to the national welfare".

These are exactly the same problems that psychiatry is concerned with and teaches its students.

Besides preventive medicine, there exist other very important medical problems, which get even more importance every day, and constitute part of social medicine. These problems are those of the elderly population, chronically ill-patients, disabled, physical and mental complications resulting from accidents (Watson - 1969, Trethowan 1968) etc., where apart from the fact that the concept of community medicine is to be applied, psychiatric

care is also needed.

In the case of elderly people, it suffices to note that the occurrence of psychological disturbances is estimated at 20-30% (Post, 1968).

True that in certain countries the problem of elderly people is not yet felt acutely at present, but there are evidences which point out to the fact that these problems will crop up. Medical schools should be in a position to foresee this situation and prepare their students from now to face these problems as well as those we just mentioned. If the future doctor is to take care of these patients, he has to understand them and be able to cope with their numerous psycho-social problems as well.

Doctor-patient relationship

A comparatively large number of books and articles have been published on doctor-patient relationship during the recent years.

Ley and Spelman (1967) in their book "Communicating with the Patient" say: " 'They never tell you anything' is a complaint frequently levelled by patients against hospital staff, particularly against the doctors". In this book the authors review studies made by a number of workers, which show that 16 to 39% of patients expressed 'serious dissatisfaction with communications' after being discharged from hospitals. And if we were to add the number of patients who mentioned 'some failure of communication', the figure will rise to 50-60%.

Cartwright (1964) and McChee (1961) show that far more patients were dissatisfied with communications rather than with other features of their hospital stay, such as food, noise, etc. All these investigations point to the fact that patients want to be kept informed of their conditions, the diagnosis, prognosis, progress, after-care and reasons for investigations.

This desire to be aware of their illness is a sign of their worries and anxieties, which partly is understandable and can be considered as a normal phenomenon.

Kenneth Walker (1957) states: "If I were to be asked to name the symptoms most commonly seen in the doctor's consulting room, I should answer without any hesitation - fear".

Questions asked by almost all patients, like: "What do you think, doctor, I am suffering from?", or "You don't think I am seriously ill?", or "Shall I get better?" clearly show their worries and fears, for, as we go on conversing with our patients, very often they eventually admit of being afraid of having something serious, such as some kind of growth. Other reasons they give for their fear are that of losing their job, or passing the illness to the other members of the family, etc.

The illness as stress itself, or apt to create a stressful situation, is to be considered anxiogenic. These anxieties may take different forms and provoke different types of defense in different persons, depending on their socio-economic situation, past experiences, standard of education and the extent of their medical knowledge. They likewise depend on the personality traits of patients.

And we know that, apart from their effect on symptoms, course and prognosis of illnesses, anxieties bring into being other ill-effects such as poor recall of instructions, advices and information given by the doctor. (Ley & Spelman, 1967).

We also know that psychologic understanding of patient is of utmost importance in doctor's work in so far as this permits him to communicate with his patient, win his confidence, create a good relationship and desire on the latter's part to cooperate, all of which results in a more accurate diagnosis and treatment.

One of the most important causes of failure in communication are the unanswered questions of worried patients. The ways for establishing co-operation consist of listening to the patient and giving pertinent answers, which in any case should be in consistence with the patient's personality, capacity, and the prediction of probable reactions. That is why we need know how to interview him, to better unveil his hidden symptoms, be able to interpret the symbols he uses in his behaviour and conversation, and get to know his personality and environment. And all these are problems that one learns in psychiatry.

The Contribution of Psychiatry towards the
Teaching of Ethical Responsibility in Medicine

Doctors are often faced with most unpredictable ethical problems. With the advancement of medicine and the development of new techniques, **unprecedented** problems appear increasingly. Old Oaths, Codes of ethics and Declarations, now fall short of modern needs and often to such an extent, that in many medical institutions professional vows are no longer used (JAMA, 1969; Edmunds & Scorer, 1967). Nonetheless a code of ethics is necessary in every profession, and indispensable in the medical profession, where the doctor is in direct contact with people and their private lives. Many authors (Ormord 1968, Pless 1967, Macdonald 1967) almost unanimously point out the necessity of a code of ethics in the medical profession and to its teaching to medical students as a means of developing in them the sense of ethical responsibility. It must be mentioned, however, that no general agreement as to the uniformity of the code has yet been reached at.

Responsibility can be considered as the acquiring of a series of complex conditioned reflexes, which develop from childhood, or, in other words, the sense of responsibility has to be acquired through learning and is

therefore subjected to the laws of learning. As Wall (1967) puts it: "the learning concerned with the development of attitudes towards facts, towards situations and problems, towards oneself as a professional person with responsibilities, towards new knowledge, novel situations ... is difficult to define ... yet in many educational contexts it is probably of paramount importance ... the way in which a student functions after he has been educated".

Besides new problems in modern medicine, many problems arise in daily contacts with patients in which medical ethics intervene. Every patient refers to the doctor with expectations, hopes and aims, and with different emotional equipment, which provoke different reactions in the doctor (Browne and Freeling, 1967). On the other hand, any medical student, with his own sense of responsibility differs from that of others and depends on his own environmental, educational and personal factors. After finishing his medical studies, he has learnt to control his emotions and to act according to medical logic. It therefore ensues that a doctor is at the same time under the influence of three kinds of stimuli, which very often are in controversy: patient's behaviour, his own personal habits and emotions, and medical logic. What is expected from medical ethics, is to bring into harmony the reactions these stimuli provoke, and to render them profitable and protective both to the patient and to the doctor.

Although laws and oaths are in general useful for these purposes, but they cannot be applied at all times and under all circumstances. Similarly, although the code of moral may be identical everywhere in today's world, yet it will differ in different cultures and in every individual of a given community.

Obviously, if a doctor has to render his reactions beneficial, he has to get insight into the stimuli that provoke them. And also he has to learn in which circumstances what reactions he should display and what ethical steps he should take. To acquire these habits, is to acquire professional behaviour with all the aspects this learning implies.

The most favourable period for acquiring these habits is no doubt the period of the student's formative years in medical schools. The student should be trained in that direction from the beginning of his studies, so that he may be in their full possession by the time his studies are over,

Therefore, from the very first year he should get acquainted with group and general psychology and the characteristic traits, mores and traditions of his own culture, and of that of the patients whom he is to treat in future. He must learn the psychology and physiology of emotions, the reactions of patients and doctors, their counter-effect on each other, and finally, the defense mechanisms. Moreover, the student should be taught which are the right behaviour and reaction in every particular situation he is faced with, taking into account patient's cultural and personal background.

It is obvious that all this cannot be limited to theoretical teaching only; the student has to see the patient in a social and cultural setting, observe his reactions, get an insight into his own reactions and thus learn and develop the requisite ethical responsibility in medicine. In our opinion the only science that can give this knowledge to the student is Psychiatry.

The place of Psychiatry in medical curriculum

From what has been said above, there exist three vital reasons in favour of teaching psychiatry in medical schools:

1. The dividing of patients into psychological and somatic categories is unrealistic and artificial, and should therefore be ceased. The student should learn to see the somatic aspects in a psychiatric patient as well as the psychiatric aspects in a physically-ill patient. He should learn psychiatry in order to form the habit of assessing the psychiatric and social aspects of every patient, no matter what the diagnosis be, and also as a clinical discipline through which he can form the concept of the integrity of mind and body in medicine.

2. To be able to handle the bulk of psychiatric patients with whom he will be in everyday contact in his future practice, he must know how to detect a psychiatric illness and how to treat it. This is specially true of family doctors, but does not exclude other specialists.

3. Psychiatry should not only be taught for the student to know it, but for him to use psychiatric methods, for the following reasons:

a) The establishing of good doctor-patient relationship. To be able to establish communication, it is necessary for a doctor to learn how to interview the patient and how to listen to him. The ideal image of this is the psychiatric interview, through which he is directed on the path of learning non-verbal communication and getting to know patient's emotions and inner wishes and evaluating them.

b) At the age when students enter a medical school, and during all the period of their studies, they pass stages of personality development. While doctors are expected by their patients and the community to behave as mature individuals from the very beginning of their professional career, they very often graduate at an age when they have not yet attained complete maturity specially as far as social maturity and proper control of emotional reactions is concerned.

In medical schools all endeavours are being made to equip students with the necessary medical knowledge, but little attempt is being made in the way of their personality education (Kemp, 1968). Recent investigations show that students have different attitudes towards medicine and towards their specialties (Juan et al 1964; Davies & Mowbray, 1968). As attitudes are acquired through learning (Walton, 1967) use can be made from psychiatric methods to form proper attitude towards medicine and patients, to accelerate maturity, to help the student to acquire befitting professional behaviour. As confirmed by Hunter's (1965) observations, psychiatry and psychology help the student to know himself better, to have proper control over his emotions and be able to eliminate unnecessary reactions and acquire in their stead reactions which will be useful to himself and his profession.

c) Psychiatry can facilitate the development of ethical responsibility through the acquisition of correct and useful habits. It likewise will help the student to situate the patient in his own psycho-social setting, evaluate the presented complaints and symptoms of the patient in that setting, and allow him to see through these his own responsibility towards the patient and to act accordingly.

It therefore ensues that in order to attain these aims, the teaching of psychiatry should begin as early as possible, and continue all through the period of university years. As it is usually done, the teaching of psychiatry should come after psychology and sociology among other behavioural sciences, in the pre-clinical years. Yet, only those facets of psychology will be of use to the medical student which are scientific and integrated in physiology and biochemistry. However, it would not be right to say

that this teaching should be, or could be uniform in all medical faculties and by uniformity we mean here that no definite rule can be fixed as to in which year it should start, because to understand and assimilate psychology youth must have a certain degree of preparedness. They come to universities with different levels of intelligence, general knowledge and psycho-social backgrounds. They must be given some time to develop at least partly, this preparedness through learning anatomy, physiology and biochemistry. Therefore it is proper to start teaching psychology from the year when physiology is taught. It is appropriate to add here that pure dynamic psychology is a boring subject for the student and not easily accepted. Its teaching causes the student to consider psychology as a fictitious subject useless in medicine and an unnecessary waste of time. And once the student forms this impression it is difficult to correct it. Therefore one must be very cautious whenever tackling a question relating to dynamic psychology.

Those aspects of dynamic psychology which are more acceptable to students, because they can see them in their everyday life, and use them in daily clinical work are defense mechanisms which are more or less synonymous to biological defenses and can be taught as an alternative of behavioural psychology.

Another part of psychology that a student needs know, is the developmental psychology and this should be taught as an integral part of physical development, which in fact it is.

These two chapters of psychology should be taught not only because of their use in medicine but because they can be profitably used to form in the student a proper attitude towards medicine and help him to "better know himself". It would be quite appropriate therefore to teach part of the lessons through seminars and group discussions.

When teaching psychiatry, the same line of conduct should be adopted, that is to say, if we want to attain all the aims which have been enumerated, through psychiatry teaching, we have to start from the early years of clinical work, more specifically drawing students' attention to all the psychiatric aspects of the patients as forming the integral part of their illnesses.

Besides general hospitals the most suitable place for teaching psychiatry are the out-patient clinics. Whenever possible, community health visitor programmes should be made use of. Here students can get fully acquainted with environmental factors and have the chance to see all those clinical manifestations of psychiatric patients that they will be faced with during their future medical practice, and learn their treatment and management.

Ecological and social settings as well as historical backgrounds of universities often differ, even in the same country. Therefore, here again, as in the case of psychology, no uniformity can be imposed on medical faculties as from where to start teaching psychiatry, and how many hours to devote to its teaching, or how extensive the theoretical part should be, or else how it should be divided during the span of years students spend at the faculty. The main point is to harmonize the theoretical teaching with clinical instructions and the teaching of diseases.

To make the concept of the integrity of medicine and psychiatry a real picture and to give students more opportunities to better perceive it, a series of steps will have to be taken which are given below:

- i Teachers in medicine should make it a point to give the psychiatric aspects of the diseases both in theory and practice. This implies that some of them may need vocational training. The student will better understand the concept of integrity in medicine when he sees

the same teacher draw his attention to the somatic and psychological aspects of the illness.

- ii However, before this somewhat ideal stage is reached, team-work demonstrations by doctors and psychiatrists will be a necessity.
- iii Radical changes should be brought in medical textbooks. Instead of allocating a meagre chapter to psychiatry at the end of the textbooks, the description of every disease should be at the same time completed by the psychiatric aspects of that disease. Also a chapter at the beginning of every textbook should be devoted to the description of psychosomatic approach in medicine. Psychiatric examination should be inserted in the chapter dealing with physical examination.
- iv More room is to be given to psychiatric subjects in medical journals and reviews.
- v Joint symposiums, researches and meetings should be organized between psychiatric and medical institutions and societies, locally as well as internationally.
- vi Students should be encouraged to take part in at least one research comprising medical, psychological and social aspects, and incited to make such investigations subjects of their theses in the case of universities where the presentation of a thesis is a requirement.
- vii As no uniformity can exist in the teaching of psychiatry in different schools, the curriculum of every medical faculty should undergo changes according to the medical and psychiatric needs of the community. With this aim in mind, it would be appropriate if in every faculty a permanent committee composed of medical men, administrators, psychiatrists, psychologists and sociologists be formed. The

duty of such committees would be to continually investigate the community needs, foresee the future one, and to make their suggestions to the University Authorities regarding the necessary changes to be brought in the curriculum, evaluating at the same time the usefulness of the new programmes.

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