WORLD HEALTH ORGANIZATION
REGIONAL OFFICE
FOR THE EASTERN MEDITERRANEAN

ORGANISATION MONDIALE DE LA SANTE
BUREAU REGIONAL
POUR LA MEDITERRANEE ORIENTALE

SEMINAR ON THE ORGANIZATION OF MENTAL HEALTH SERVICES
Addis Ababa, 27 November to 4 December 1973

EM/SEM.ORG.MH.SERV./17
ENGLISH ONLY

PSYCHIATRY IN BASIC MEDICAL EDUCATION

(Psychiatry in the Medical Curriculum)

by

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In a well-ordered world, where everyone behaved in a rational way, the planning of the undergraduate medical curriculum would be a straight-forward matter. In every country, curriculum review committees would monitor :

(a) on the one hand those aspects of the sciences basic to medicine which a doctor must know in order to practise his profession efficiently, and

(b) on the other hand, the changing pattern of morbidity in the society in which he is going to practise.

In the light of these surveys, priorities could be drawn up for subjects which should have greater or lesser emphasis in the medical school.

Unfortunately, life is not like that. Several factors impede purely rational planning of the curriculum. Prominent among these is inertia : medical teachers are pre-disposed to go on teaching in the way that they were taught and to cling to the prejudices imparted by their erstwhile teachers. Change requires mental exertion, and this tends to be unwelcome. Consequently, constructive change in the curriculum requires more than the exercise of rational planning : it also requires a powerful "push" from some individuals or groups who feel strongly about the need for change.

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Such a "push" was given to American medical education as a whole, by the publication of the Flexner Report in 1960; as a result of this report, many of the weaker schools were closed down and the standards of scientific teaching and research in American medicine were significantly raised.

One would like to be able to say that a searching, critical inquiry into the shortcomings of medical education was always followed by dramatic changes : but this has not been the invariable rule : the Goodenough Report of 1944 contained an excellent critique of shortcomings in British medical schools - but implementation of many of its recommendations had to wait for the additional "push" of the Todd Report of 1968; similarly in India, the Bhore Report of 1946 pointed to many areas in need of reform in Indian medical education, but its implementation did not become general until after the publication of the Mudaliar Report in 1955.

In the field of psychiatry itself, an important landmark was the survey of teaching in US medical schools carried out by Dr Franklin Ebaugh in 1940; but it was not until after the second world war that major changes took place. Here, a key event was the "Ithaca Conference" of 1951, which drew up new standards for the teaching of behavioural science and clinical psychiatry in the undergraduate course.

Several countries have formal institutions, charged with the supervision of medical education. In Britain, this is one of the responsibilities of the General Medical Council, which produces, every ten years, a slim booklet, of "Recommendations as to Basic Medical Education". It is interesting to note that as recently as 1957, the only reference to behavioural science teaching in these Recommendations was the laconic phrase : " Instruction should be given in the elements of normal psychology". Ten years later,

the corresponding passage in the Council's Recommendations read as follows :

"In the Council's view the study of human structure and function should be combined with the study of human behaviour. The Council considers that instruction should be given in those aspects of the behavioural sciences which are relevant to the study of man as an organism adapting to his social and psychological, no less than to his physical, environment. Instruction in the biological and sociological bases of human behaviour, normal emotional and intellectual growth, and the principles of learning theory should be included."

In the same Recommendations, the Council had this to say about the teaching of psychiatry to medical students :

"Emphasis should be laid on the common neurotic and personality disorders and on the ubiquitous nature of emotional disorder in all types of illness. The Council considers therefore that Psychiatry can be usefully taught, not only in the psychiatric wards and out-patient departments, but in all wards of the hospital, as an integral part of the study of clinical medicine. The student should obtain understanding of the range of psychiatric disorders, including acute mental illness, and should receive instruction in clinical methods basic to the subject. Students should be introduced to the care of the chronic psychiatric sick. Instruction in psychiatry should include the elements of mental sub-normality and child psychiatry; this instruction should, where opportunity permits, be integrated with the teaching of paediatrics."

In 1968 came the publication of the Todd Report, which has already had a major impact on medical curriculum planning in Britain. Among the topics

singled out for particular attention in this Report were the teaching of Behavioural Science and of Clinical Psychiatry. A survey of current teaching in these fields, specially carried out for the Royal Commission, showed that teaching in the former area varied from none to over 100 hours, in different UK medical schools, while there was an equally wide range in the provision of clerkships and of contact with patients during the clinical course (Carstairs et al, 1968).

The Todd Report made explicit recommendations in order to ensure that all schools would attain at least an acceptable minimum of teaching in each of these areas.

In considering the reasons for the apparent increase in attention given to psychiatry in the 1967 GMC Recommendations and in the 1968 Todd Report, personal factors cannot be ignored. The presence of Sir Denis Hill on the Council undoubtedly influenced the wording of the former; and the fact that the Todd Commission included three individuals (Lord Platt, Professor Titmuss and Professor Carstairs) who were keenly interested in the study of human behaviour as an essential part of medical education, similarly influenced the latter.

Individuals have played a conspicuous part in the advancement of psychiatric teaching in certain developing countries. Outstanding examples have been Professor T.Y. Lin in Taiwan; Professor Lambo in Nigeria; Professor Tigani el Mahi and his successor Professor Taha Baasher in the Sudan, and Professor Kusumanto Setyonegoro in Indonesia. All of these have helped to ensure that psychiatric teaching has received due attention in the medical schools of their respective countries - but it is equally true that where psychiatry has not found an influential champion, its place in medical education is generally

sadly neglected. Still, in the majority of developing countries, there is little or no teaching of behavioural science, while in all too many schools only a few hours are given to clinical psychiatry. Commonly, attendance at these lectures is optional, there being no formal examination, and first-hand clinical experience is the exception rather than the rule. As a result, in many countries doctors are graduating with totally inadequate preparation for this important aspect of their future practice.

There are two international bodies which have, in recent years, taken note of this situation and which have exerted themselves to do something about it. One is the World Federation for Mental Health, which has conducted a series of Seminars and Workshops in different regions, bringing together psychiatrists and other mental health workers from neighbouring countries to discuss how to improve their mental health services and training. Such meetings have been held in Hong Kong (1968) Kampala (1969) Montreal (1969) Singapore (1970) Cairo (1970) and Madurai (1971). World Federation of Mental Health also sponsored a series of post-graduate seminars on the special needs of trainees intending to work in such countries, which were held in the Edinburgh University Department of Psychiatry in 1968, 1970 and 1972. This topic has also been prominent in the annual meetings of WFMH - perhpas especially in its 1973 Jubilee Meeting, held in Sydney, whose theme was : "Cultures in Collision".

The other interested international body has of course been WHO. Already in 1961 that body published a report of an Expert Committee on Mental Health, entitled "The Undergraduate Teaching of Psychiatry and Mental Health Promotion" which spelled out the minimum requirements for teaching in this area. These included 40 hours teaching of psychology and 20 hours of sociology during

the early years of the course, and 60 hours of formal teaching in clinical psychiatry followed by one month's full-time clinical clerkship. Under each of these headings, the report indicated topics which should be covered. This report still represents a target which has been attained, or surpassed, by only very few medical schools in developing countries. It has, however, proved invaluable as setting a standard against which countries can measure their own current performance.

In order to narrow the wide gap which still exists between the minimal requirements indicated in the above report, and the actual state of affairs, Regional Offices of WHO have promoted a series of seminars on "Psychiatry in Medical Education" in which representatives of all countries of the Region have taken part. Such seminars have been held in Lima, Peru (1967) in Agra (1968) New Delhi (1970) and Colombo (1972) and in Alexandria (1970).

Certain harsh realities which have been revealed during these seminars help to explain why the prevailing standards of psychiatric teaching are still often very far short of the WHO recommended minima. During the current year of 1973 the writer of this paper has personally visited his colleagues in each member country in the South-East Asia region of WHO, and has been compelled to recognize the formidable obstacles which they face. The first and most rational of these is the belief, held by health planners and Directors of Health Services, that first priority must be given to the control of communicable disease, and to improving sanitation and nutrition. Only after these life-saving measures have been carried out will increased attention be given to chronic and non-communicable diseases - including all forms of mental disorder - which cause distress and disability but are seldom fatal.

Already, many of the former killing diseases are being brought under control, so it is timely for the developing countries to look ahead and to consider the services which will be needed to ensure that their citizens do not only survive, but enjoy a better quality of life : but here, certain less rational considerations intervene to delay or even obstruct the advancement of psychiatry in medical education.

Foremost among the obstacles are prejudice and ignorance on the part of our other medical colleagues. Many of the teachers who are now in key positions in medical schools in developing countries have themselves undergone long years of training, both at home and abroad, in which little or no attention was given to the prevalence of psychiatric disorders in general medical care. Instead of acting as educators of public opinion, towards a better understanding of the nature of mental illnesses, and the new methods of treatment now available, all too many Professors of Medicine, Surgery, Anatomy and Physiology - and even all too many Deans and Principals of Medical Colleges - still hold quite out-dated ideas about psychiatry, regarding it as exclusively concerned with the treatment of the insane in "mad-houses".

There are many honourable exceptions to this rule; but it still holds true for the majority of senior teachers whom the writer has met in eight South-East Asian countries. At times it even seems that senior medical men are proving slower to learn about changes in psychiatry than are educated members of the public at large. This "time-lag" becomes prolonged where psychiatry is relegated to a very minor and peripheral role in the medical school, because this prevents the inter-action between psychiatrists and other doctors in their daily work, which forms the best type of post -graduate education.

It is, therefore, not surprising that among the recommendations of nearly all the seminars organized by WHO or by WFMH certain necessary pre-requisites for the improvement of psychiatric teaching have been stressed. These are :

(1) Creation of an independent Department of Psychiatry in each Medical School, under the direction of a Professor, with supporting staff.

(2) Provision of in-patient and out-patient psychiatric services as integral parts of the main general teaching hospital.

(3) A separate examination in psychiatry, which must be passed before the student can graduate; or inclusion of a significant amount of questions on psychiatry in the medical finals.

(4) Satisfactory performance of a clinical clerkship in psychiatry during the undergraduate course, or as part of a rotating internship should be a pre-requisite before awarding the M.B. degree.

These are still the immediately pressing needs in a great many medical schools in developing countries. Only when they are met can we look forward with greater confidence to the implementation of the recommendations of the 1961 WHO Expert Committee report, or to those indicated in the reports of the committees, seminars and workshops which have been mentioned in this paper, and are listed in the bibliography.

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