The psychological care of medical patients: a challenge for undergraduate medical education

ABSTRACT—A recent joint report by the Royal College of Physicians and the Royal College of Psychiatrists has argued the case for improving the psychological and psychiatric care of medical patients. It makes a number of suggestions about staff education and training but does not specifically address undergraduate medical teaching. Following recommendations by the General Medical Council, UK medical schools are reorganising their undergraduate curricula with a new emphasis on equipping students for the preregistration year. These two important sets of recommendations present a challenge to medical education. In this article we report on a meeting which considered what the newly qualified doctor needs to know about psychological and psychiatric aspects of general patient care, how far the current psychiatric curriculum meets those needs, and how it could be improved.

The Royal College of Physicians and the Royal College of Psychiatrists have recently published a joint report urging improvements in the psychological and psychiatric care of medical patients [1]. The report reviews the evidence, documenting the importance of psychological problems and psychiatric illness in medical patients, and recommends doctors working in non-psychiatric settings to become proficient in detecting and managing them. Although the report does not specifically address undergraduate medical education, the fulfilment of its recommendations would require a change in current teaching. The General Medical Council has also produced a report entitled *Tomorrow's doctors* [2] which recommends a core curriculum for undergraduate medical education, with an emphasis on the knowledge, skills and attitudes required by the preregistration house officer. These two sets of recommendations present a significant challenge to those concerned with the teaching of medical students. In this article we consider how a change in the emphasis of the current psychiatric curriculum and a greater integration of undergraduate psychiatry teaching with that of medicine could help to meet this challenge.

M SHARPE, MA, MRCP, MRCPsych, *Tutor in Psychiatry, University Department of Psychiatry, Warneford Hospital, Oxford*

E GUTHRIE, MSc, MD, MRCPsych, *Senior Lecturer in Psychiatry, University Department of Psychiatry, Manchester Royal Infirmary, Manchester*

R PEVELER, MA, DPhil, MRCPsych, *Senior Lecturer in Psychiatry, University Department of Psychiatry, Royal South Hants Hospital, Southampton*

E FELDMAN, MA, DM, MRCPsych, *Senior Lecturer in Psychiatry, University Department of Psychiatry, Queen's Medical Centre, Nottingham*

The needs of the newly qualified house officer

What does a preregistration house officer need to know about psychological and psychiatric aspects of medicine? It is clear that they need to know about the nature and management of severe mental illness such as schizophrenia. However, they must also know about other psychological and psychiatric problems more commonly encountered in general practice and on hospital wards. These are highlighted in the Joint College Report [1] and include emotional distress and depression, delirium, alcohol misuse, medically unexplained physical symptoms, and deliberate self-harm [3–5]. The house officer must also be able to deal with patients' and relatives' distress, communicate information sympathetically, care for dying patients and those with intractable illness, negotiate with non-compliant patients and handle complaints. Learning how to look after both their patients' and their own emotional needs may not only improve medical care but also reduce the prevalence of 'burn out', drug and alcohol abuse, suicide and other psychological problems which currently afflict the profession [6].

Existing teaching

Although few of the aforementioned topics are the exclusive province of psychiatry, they are all areas to which psychiatry teaching might make an important contribution [7]. In order to determine the extent to which undergraduate teaching in psychiatry currently addresses these topics, one of us (EG) carried out a survey of 13 UK medical schools during 1994. Its aim was to establish the total amount of psychiatry teaching, the content of the lecture courses, and the nature of the clinical experience available to students. The key findings are listed in Table 1. The average amount of time specifically allocated to psychiatry was approximately eight weeks. Almost half the formal teaching (and even more of the clinical experience) was devoted to major mental illness and to psychiatric subspecialties; little time was allocated to problems of the type commonly seen by the newly qualified house officer. Furthermore, with one or two notable exceptions, relatively little attention was paid to teaching communication skills and how to give bad news. While it was not possible to determine the attitudes conveyed by these courses, our own experience of medical

Table 1. Undergraduate teaching in psychiatry (October 1994)

Topic	Mean % time allocated on lecture course
Severe mental illness	37.5
Neurosis, drugs and alcohol	17.5
Psychiatric subspecialties	15.0
Psychological treatments	7.5
Organic states	5.0
Multidisciplinary team working	5.0
Suicide and deliberate self-harm	2.0
Psychological care of medical patients	1.5
Miscellaneous	9.0
Number of medical schools offering attachments to a liaison psychiatry firm	6/13
Number of medical schools offering psychiatry teaching during medical/surgical attachments	3/13

Medical schools surveyed: Birmingham, Cambridge, Edinburgh, Leeds, Leicester, Liverpool, Manchester, Nottingham, Oxford, St Bartholomew's, Southampton, UCL, UMDS.

Table 2. Models for teaching

1. **Lecture courses during medicine and surgery blocks**
   - *For:* Relatively easy to organise, requires few teachers: attendance can be enforced if the content is examined as part of the final examination.
   - *Against:* Lectures to large groups are not a good way of learning and lectures are an inefficient way to teach skills and attitudes.
2. **Joint seminars and skills training during psychiatry or medicine/surgery blocks**
   - *For:* A good way of encouraging self-directed learning and imparting skills and attitudes.
   - *Against:* More costly in terms of teaching manpower than lectures and therefore availability is limited. Difficult to involve senior physicians during psychiatry teaching blocks if based away from the general hospital; difficult to involve psychiatrists during medicine/surgery blocks unless a liaison psychiatrist is in post.
3. **Joint medical–psychiatric case conferences**
   - *For:* Relatively easy to organise, requires few teachers, learning around cases is memorable, gives a model of how specialties may work together effectively.
   - *Against:* Attendance is sometimes biased: those who most need to learn do not come.
4. **Liaison psychiatry attachment**
   - *For:* Appropriate experience for learning about psychological care of medical patients.
   - *Against:* Very few attachments available as these services are poorly resourced; needs to be combined with attachments in other settings, or other core curriculum areas could be neglected.

students and junior doctors suggests that they frequently regard psychiatric skills as applicable only to psychiatric patients.

The proposal for change

With these observations in mind, a group of academics concerned with the undergraduate teaching of psychiatry (see acknowledgements) met in October 1994. Their aim was to suggest how to make psychiatry teaching more relevant to the preregistration year. It was agreed that undergraduate teaching in psychiatry had an important role in teaching students about the psychological care of all patients, and that it should remain a core subject in the new curriculum. It was also agreed that existing teaching about major mental illness should remain an important part of the psychiatric curriculum. The change proposed was that teaching in psychiatry should enjoy a greater degree of integration with the teaching of medicine and surgery than hitherto and that a greater proportion of the time allocated to psychiatry should be devoted to topics of relevance to the preregistration house officer. How could this be achieved?

Effecting the change

The emphasis of existing teaching in psychiatry could be changed to devote more time to the psychological problems most frequently encountered in general medical practice. A few universities already include some psychiatric teaching during medical or surgical attachments [8], but they remain the exception. Although psychological issues are undoubtedly addressed in primary care attachments and in the general hospital wards of medical schools, this experience could be enhanced by the involvement of appropriately skilled psychiatrists. The all too common separation of medical and psychiatric services is, however, a limiting factor in attempts to integrate medical and psychiatric teaching. Fortunately, the recent introduction of psychiatric services to general hospitals, so-called liaison psychiatry, offers a potentially important resource for the teaching of a redesigned psychiatric curriculum. Liaison psychiatrists have already reported how psychological aspects of medical practice can be taught through clinical topic-based seminars [8,9] and by a psychiatric contribution to the communication skills training provided by doctors from various specialties [10]. A specific student attachment to a specialist liaison psychiatry or behavioural medicine service can be particularly valuable [11].

Practical strategies for teaching the psychological aspects of general medicine are listed in Table 2, together with the advantages and disadvantages of each. As well as being included in the medical curriculum, psychological aspects of medicine and psychiatry should also be included in the final examination of these subjects.

Conclusions

The joint report of the Royal Colleges of Physicians and Psychiatrists has highlighted current shortcomings in the psychological care of medical patients. The General Medical Council has recommended changes in the undergraduate medical curriculum. Taken together these recommendations challenge medical schools to do better in preparing the preregistration house officer to meet the psychological needs of his or her patients. We believe that as well as teaching about specifically psychiatric topics, including severe mental illness, psychiatrists could also contribute to the teaching of important general aspects of medical practice. In order to achieve this the psychiatry curriculum will have to change and become more integrated with that of medicine. Although much can be done immediately, the further development of liaison psychiatry offers a valuable resource to those concerned with both the psychological care of medical patients and the education of tomorrow's doctors.

Acknowledgements

The ideas in this article were developed during a workshop concerning the role of psychiatry in medical education held at the Royal College of Psychiatrists in October 1994. The authors wish to acknowledge the contributions of Dr Colin Coles, Professor Tim David, Dr Linda Gask, Professor Charles George, Dr Tony Hope, Dr Allan House and Dr Stephen Potts.

References

1 Royal Colleges of Physicians and Psychiatrists. *Joint working party report: the psychological care of medical patients; recognition of need and service provision.* London: RCP and RCPsych, 1995.
2 General Medical Council. *Tomorrow's doctors; recommendations on undergraduate medical education.* London: GMC, 1993.
3 Feldman E, Mayou R, Hawton K, Ardern M, Smith EBO. Psychiatric disorder in medical inpatients. *Q J Med* 1987; **63**:405–12.
4 Mayou R, Bass C, Sharpe M. Treatment of functional somatic symptoms. Oxford: Oxford University Press, 1995.
5 Owens D, House A. General hospital services for deliberate self-harm. Haphazard clinical provision, little research, no central strategy. *J R Coll Physicians Lond* 1994; **28**:370–1.
6 Pilowsky L, O'Sullivan G. Mental illness in doctors. *Br Med J* 1989; **298**:269–70.
7 Sensky T. The place of the psychiatrist in the new undergraduate medical curriculum. *Psychiatr Bull* 1994; **18**:557–9.
8 Cantwell R, Brewin J. The new undergraduate curriculum: implementing the changes in Nottingham. *Psychiatr Bull* 1995; **19**:482–4.
9 Sensky T, Thompson C. The development and evaluation of a method of teaching liaison psychiatry to medical students. *Med Educ* 1989; **23**:174–8.
10 Hope T, Fulford KW. The Oxford Practice Skills Project: teaching ethics, law and communication skills to clinical medical students. *J Med Ethics* 1994;**20**:229–34.
11 Weddington W, Hine F, Houpt J, Orleans C. Consultation-liaison versus other psychiatry clerkships: a comparison of learning outcomes and student reactions. *Am J Psychiatry* 1978; **135**:1509–12.

Address for correspondence: Dr M Sharpe, Tutor in Psychiatry, University Department of Psychiatry, Warneford Hospital, Oxford OX3 7JX.