Education for Appropriate Psychiatry

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SUMMARY

Appropriate psychiatry depends on the careful delineation of educational objectives in terms of the knowledge, skills and attitudes that doctors can be expected to use, the development of suitable learning experiences and methods of evaluation to test whether the objectives have been attained. A method for the analysis of objectives is described, as well as techniques to facilitate learning.

Clinical skills are not enough in planning postgraduate training in the South African context. Managerial and educational skills should also be fostered, as well as the personal growth and development of the trainee. Special attention should be given to preparing the psychiatrist to meet the needs of different cultural groups. A case is put forward for the development and acceptance of a single basic qualification of clinical competence for psychiatrists in South Africa and it is proposed that the F.F. Psych. should fill this gap.


It is a matter of concern to the medical profession that we should teach our students the right things about psychiatry. Most psychiatric illness in the community is not dealt with by specialist psychiatrists, but by family doctors — not to mention gynaecologists, gastro-enterologists, nurses, social workers, teachers, personnel managers and the rest. We should therefore be trying to reach them when we can, which means mostly as undergraduates, for this is all the formal training in the subject most of them will ever get. It should moreover, be a very practical sort of training, for instance, to be able to identify psychiatric conditions quickly, to know which will respond to remedies they themselves can administer, who must be referred and to whom.

The after-care of treated patients in the community is an increasing part of the work of general practitioners. Are they equipped to do it? Similarly, multidisciplinary team work is the essence of modern psychiatry. The family doctor should not be struggling alone with a chronic alcoholic or an inspissated neurotic, for example, but should be able to use the combined efforts of psychologists, social workers, psychiatrists, and so on. Do we teach our students how to work in such teams?

We generally teach them about the classic syndromes. For example, we might enumerate the symptoms and signs of schizophrenia; dissect out its four main subdivisions and eight intermediate types; describe what is known of its causes and give information about the treatment of acute or extreme cases. Hardly ever do we venture into the tactics of how to get a chronic schizophrenic living at home to take his pills, or how to distinguish adolescent turmoil from early schizophrenia. This can be called 'appropriate psychiatry'.

After all, the main elements of the subject are few as far as the average practitioner is concerned. The neuroses all have a family likeness and similar tactics of management; the handling of organic dementia and deliria can virtually be reduced to a formula as far as the general practitioner is concerned, no matter what the cause; and the psychotropic drugs he will use can be counted on the fingers of one hand — a few anxioytics, antidepressants and the phenothiazines. The elements of the simpler forms of psychotherapy can be fairly easily taught, even to large classes.

The waiver is often made that there is not enough time in the undergraduate curriculum, or that classes are too large, but effective teaching methods can counter this. There is never an excuse for a study course consisting only of a series of lectures and a few demonstrations in the local mental hospital. The very least any self-respecting department should provide, whether the course be a few months or a few weeks, is supervised, personal, clinical experience, tuition in interviewing and experience in psychotherapeutic procedures. It is possible to do this, even with a small teaching staff, using small group methods and some of the newer teaching techniques, particularly closed-circuit TV, but it does require careful planning and a considerable degree of commitment. It is essential, however, to attempt educated behaviour rather than the cant and cackle of learned psychiatry.

Educational planning starts with determining exactly what it is that you wish the student to be able to do at the conclusion of his training — what we call behavioural objectives, in short, performance. They are twofold — an over-all one which corresponds to the north-pointing arrow on a map, and the details or by-ways that the new doctor can be expected to take in practice. There can be no real purpose to an educational endeavour without this preliminary delineation of aims and objectives.

UNDERGRADUATE TEACHING

The over-all goal defines the scope, intensity and extent of teaching. At the University of Cape Town it was formulated as follows:

To be able to deal with the emotional and psychiatric problems of patients at the level of a competent general practitioner, using his own resources and those available in his community.

Note that the definition is in terms of educated behaviour rather than cognitive knowledge.
As regards detail, that is, the knowledge, skills and attitudes that the doctor needs to develop, one difficulty is that we do not always know how a good doctor should perform in a given situation; another is how to train the student so that he will still be good in 20 years' time. A partial answer is to place less emphasis on facts, many of which become obsolete in a short time and are to be found in books anyway (rather teach them how to use a library and reference systems), and to encourage higher order mental skills, since these encompass lower forms of cognitive learning such as the ability to recall information.

We aim, therefore, at the ability to conceptualise, to abstract and synthesise in the clinical situation, to be able to move from the known to the unknown, and from the familiar to the unfamiliar, to face up to a new clinical situation, to take a critical and balanced view of a medical problem, to take responsibility for one's own learning, to develop caring concern for patients, and so on. These high-sounding phrases are not enough, of course; there must be a precise specification of each expected performance so that the student knows what to aim for, and we, what to teach.

This involves a task analysis, which is done by plotting each behavioural objective against the contents of the course, i.e. those aspects of psychopathology, aetiology, clinical syndromes, therapeutics, etc., that we consider important. This is done in the form of a grid consisting of content under which are listed psychopathology, psychological processes, aetiology, clinical syndromes, childhood psychiatry, adult psychiatry, psychogeriatrics, community psychiatry, social psychiatry, transcultural psychiatry, forensic psychiatry, psychotherapy, emergency psychiatry, preventive psychiatry and mental retardation, on the abscissa, and behavioural objectives such as knowledge and understanding, clinical skills, managerial skills, interpersonal skills, educational skills, personal growth, professional attitude and research abilities, on the ordinate. The contents of each square have to be considered, argued and refined, and one ends up by questioning every basic assumption ever made about psychiatry. It is a large task — and one may well regret having started — but it is fascinating, and I believe that unless one goes through the process, one cannot say that the job of educational planning has been done properly — the rest is just syllabus juggling. In our Department we ended up with a long list detailing the separate knowledge, skills and attitudes that were required, and these were summarised and circulated to both students and staff (Appendix I).

The next step is to devise a learning experience for each item and finally to develop a test to demonstrate whether the student has actually learned from it. Take, for example, the objective of clinical judgment. This is demonstrated by the student being able to (a) recognise the seriousness of a clinical situation; (b) produce the right diagnostic hypothesis; (c) discard irrelevant factors; (d) decide in a situation of uncertainty on the most likely possibility; (e) select and modify investigative and treatment techniques; and (f) assess the prognosis.

In this case the appropriate learning experience was the presentation of a case of suicidal depression on closed circuit TV. The evaluation of behaviour was done by discussion with tutor (items (a), (c), (e) and (f)), and by means of a structured questionnaire (items (a), (b), (d), (e) and (f)).

After planning comes action, and we are now ready to consider the next task of the teacher — to motivate and organise learning. Note that the word 'teach' which, although perfectly respectable, is not used, since it places the emphasis on the efforts of the instructor. 'Learning' places the responsibility (and the opportunity) where it belongs — with the student — and this is what good teaching is all about.

**Conditions Necessary for Effective Learning**

These have been enumerated by Miller.⁴

1. The objectives are known to the student.
2. They are meaningful and relevant to him.
3. He actually participates in the learning process.
4. Learning is continually evaluated by feedback.
5. The programme is paced to his individual ability.

Our job, then, is to see that the student has appropriate learning experiences and ends up being able to do without us — to learn for himself. The fact is, people love to learn, and it should be our intense concern that, after having passed through our hands, this at least remains. This is the only educational principle that really counts — and not boring your audience. Primary school teachers know this better than university teachers, who so often succeed only in educating the bloom off eager young minds. In psychiatry particularly, this should not happen since our subject matter is intrinsically so fascinating. Why then, with the cream of the intellectual crop, do we produce so many psychiatric 'yahoos' in the medical profession? There is no question that we could all do with proper instruction in teaching techniques and educational psychology, but this alone is not enough. What we need is the same sort of caring concern for our students that we wish them to develop for their patients. Too often though, we are more concerned with the subject we are teaching than with the subject who is to do the learning; in other words, topic-orientated rather than student-centred psychiatry — this is the great educational trap.

**Evaluation**

The prime reason for evaluation (or examinations) is as a learning aid to let the student know what more he needs to know. Their other value is in testing the effectiveness of a programme of teaching; and only third in importance is their use for certification purposes. In other words, their main purpose is to help the student learn.

Students have already passed through a rigorous selection procedure, that is, getting into medical school, reaching their 5th year, or achieving the M.B. Ch.B. in the case of postgraduates, so that we should be able to take it for granted that, having gone through our course, they know what they need to know, if our teaching programme has been good enough. If they fail, we have failed, otherwise the student has a mental block to learning, or an emotional disturbance or psychiatric illness. If so, we should have detected this early enough to rectify the situation, and it is...
important to build checks into the teaching programme to pick up this sort of problem during the year.

Knowing how to evaluate performance, like teaching, does not 'just come'. Most medical examinations are poorly constructed and completely unvalidated for measuring the attributes they purport to assess. In fact, there is evidence that they mostly measure the single dimension of 'general knowledge'. Moreover, examiners are unreliable— they use different standards, do not usually consult to correct to a common mean, mark with different degrees of severity, and so on. Evaluation is a skilled and complex task, but there is a good deal of new and useful material available on the subject, and it is possible for medical school teachers to improve their examining systems enormously by taking this into account.**

**POSTGRADUATE PSYCHIATRIC EDUCATION**

**Training and Examination System**

Psychiatry has come of age in South Africa—every university has a department of psychiatry and a professor; there has been a co-ordination of all services under the Department of Health, and the Society of Psychiatrists is strong and effective. At this time of consolidation and new maturity, we need to take a hard look at the way we are training and qualifying psychiatrists.

Again, the prime question is: 'Who are we training for what?' The aims and objectives must be worked out in the same way as for undergraduates. Certification of competence is an important matter.

There should be one basic specialist qualification for the whole country, and this should concentrate on clinical competence rather than academic excellence. Registration as a specialist must imply not only that the person has a higher degree and certain experience, but that he can perform his professional tasks well. The regulations of the South African Medical and Dental Council specify the experience that is required, but they cannot ensure that it gives rise to appropriate behaviour—only our own profession can do this by means of planned objectives, supervised training and intensive testing of the prospective psychiatrist. I believe that the F.F. Psych. is the most suitable qualification for this purpose because of its essentially clinical nature and because it has the advantage of centralising and standardising the examination and also because the examining body is an independent organisation. This is the trend everywhere; in Britain the M.R.C. Psych. has superseded all but a couple of the many D.P.M.s and these, too, will go in time; in Australia and New Zealand the F.A.N.Z.C.P. is the main postgraduate examination; in the USA, certification is by a specially appointed board which serves the whole country.

This does not mean that the universities are no longer concerned. Their role is to train and prepare candidates for the examination—and they will, of course, continue to offer their own higher degrees, namely the M.Med. or the M.D., which are more appropriate as academic or research qualifications. In my view, the D.P.M. should disappear, because although it has served us well and the standard of our two D.P.M.s is very high, a diploma has not enough prestige to serve as the *imprimatur* of professional competence in an important branch of medicine.

It is necessary however, that the syllabus and requirements for the F.F. Psych. be reconsidered, and a committee is already working on strengthening its clinical nature. The feeling is that no candidate should be allowed to write until he has had three years of full-time supervised experience in psychiatry, although we recognise that time spent in training is no guarantee of its adequacy—for instance, it serves little purpose to spend six months studying child psychiatry unless you are satisfied that it is not merely one week's experience repeated 26 times! Moreover, there is little point in sending a registrar to an outlying mental hospital for long periods, where he does little else but admit cases, give ECT therapy and write statutory reports. The safeguard is that training be done in a university department, because this is the best guarantee of rigour, and it is only there that sufficient teaching talent can be gathered.

Sustained supervision and ongoing evaluation are stressed. This is best accomplished by tutors and consultants in the teaching hospitals, but in the interests of standardisation, it is recommended that all reports be scrutinised by the head of the teaching department concerned for evidence of adequate experience and competence.

The principle of accreditation of training institutions is important, that is, that they conform to certain specified standards, such as that registrars have supervision for at least two hours per week, of which one must be individual; that there is enough time for study (that is, at least one full day off per week); and that there is a complete range of clinical facilities available.

Full clinical responsibility under supervision is essential, and certain clinical experience must be mandatory, i.e. in a department of psychiatry of a general hospital, emergency care, psychogeriatrics, partial hospitalisation, outpatient and community care, child and adolescent psychiatry, intensive psychotherapy, milieu therapy and alcoholism. The details are still being worked out and it is to be hoped that the list of acceptable experience and institutions will key in with that of the Medical Council so that there is only one set of requirements.

The examination itself will continue to be written in two parts, but the principle of staging is important; that is, if the candidate's clinical performance is unsatisfactory, he may not be allowed to proceed to the next part of the examination.

**Managerial and Educational Skills, and the Personal Growth and Evolution of the Trainee**

Managerial skills are not normally taken into account in training psychiatrists, but in South Africa, with its need of development work, every psychiatrist should be able to undertake the organisation of an outpatient clinic or a community service. He should know how to maximise the technical and therapeutic skills of the staff who work with him and also how to utilise and co-ordinate existing com-
community facilities. These skills can be specifically taught.

The same applies to educational skills. The purely clinical task is not enough in a country with sparse psychiatric cover, where every psychiatrist is willy-nilly an educator in the cause of mental health. He must be able to train others as part of his vocation, and know how to share his knowledge and how to use contemporary educational approaches. The very least is that he be able to communicate well in lectures and seminars, and write clearly and meaningfully. Above all, he should leave our hands with a commitment to teaching others, particularly medical students and members of the therapeutic team.

Last but not least is the objective of personal growth and evolution. If the best psychiatrist is the most fully developed person, then I believe this should be our goal, and those of us who train psychiatrists should hold ourselves responsible to some extent for their psychological growth and personal evolution, which are unfortunately usually left to develop by themselves, and sometimes never do. This could be no more than a pious resolution, unless it is broken down into specific objectives. Difficult as the task is, it is possible to detail some of these objectives that look feasible, and more important, testable. For instance, the psychiatrist at the conclusion of his training should be able to take clinical decisions and responsibility within the limits of his own competence; show increasing ability to deal with problems as they arise; be able to do productive work; be able to tolerate ambiguity and uncertainty, dependency, hostility and anxiety in relationship with patients, seek help and advice and consultation when he needs it; be able to examine his attitudes and behaviour towards his patients, including counter transference; be flexible to the needs of a situation; be able to work in a subordinate capacity if necessary and take leadership if the situation demands it; join with others and feel part of a group; and also welcome new ideas and experiences.

Perhaps this amounts to an impossibly high standard of mental health, and how many of us would pass muster? Nevertheless, it does provide a direction for teachers and an impetus for students, and for this reason, it should be included in training programmes.

**SOCIAL APPROPRIATENESS**

Are we teaching a type of psychiatry which is really suited to the needs of the South African community? I think we train our students mostly for the kind of patients with whom they are most comfortable, i.e. a middle-class clientele, and as a result, a glaring inequality in services develops, not by design but by force of training and circumstances. What about tribal and township Blacks, urban Indians and rural Coloureds, and persons from lower socio-economic groups of all races? There is a huge cultural difference between the average graduate, the tribal Zulu and the family of a dustman working on the Cape Flats, and the barrier of the non-intellectual mind is so real that it may imply the inability to speak the other person’s language. Do we teach our students how to reach these people on their own terms? Clerking a few such patients in a mental hospital, or a lecture on cross-cultural differences does not meet the case.

The need is for purposeful instruction and guided supervision. We have been neglecting this for too long.

These then are what I consider to be the main requirements for psychiatric education in the 1970s. Boiled down, it comes to this — careful planning, the use of modern educational techniques, and an insistence on quality control. We already produce psychiatrists; now let us ensure that they are good ones.

**APPENDIX I: OBJECTIVES OF THE UNDERGRADUATE COURSE IN PSYCHIATRY AT THE UNIVERSITY OF CAPE TOWN**

To Acquire Knowledge and Understanding of the Basic Terms, Facts, Concepts and Principles of Psychiatry

These are described in lectures, demonstrations, notes, tutorials, etc., and in one of the recommended textbooks of psychiatry. This includes symptoms, syndromes, abnormal behaviour, aetiology, psychodynamics, psychology, methods of investigation, treatment and aftercare as well as prevention.

**Demonstrated by the student's being able to** recognise, recall and explain what he knows in relation to normal and abnormal behaviour; and to seek and find information in textbooks, journals, *Index Medicus*, from the staff, etc.

To Acquire Clinical Skills

This includes the development of clinical judgement.

**Demonstrated by the student's being able to** obtain a clear and ordered history as described in the Schema for Case History Taking; elicit the main symptoms; follow up cues given by the patient; obtain information in a manner appropriate to the patient's understanding and co-operation; use additional sources of information (family, employer, school reports, etc.), and elicit and describe clinical signs in a clear and systematic manner as described in the Schema for Case History Taking. He must also be able to use appropriate diagnostic techniques and tools, i.e. testing for memory, intelligence; link relevant information; analyse and interpret symptoms and signs; put the findings together in a succinct and sequential manner and present them clearly, either verbally or in writing, and put forward tentative diagnostic possibilities and distinguish between them on the basis of the facts and probability. He must have the ability to test evidence; persist until a definite diagnosis is made; recognise when and what further data or procedures are necessary, and how to obtain or perform them such as EEG, psychometry, lumbar puncture, etc.; recognise associated or contributory medical, social or psychiatric factors; make effective clinical decisions; recognise the seriousness of a situation and establish the hierarchy of a patient's needs; select and modify techniques and treatment according to the specific needs of the patient and his response; and assess the prognosis. He must be able to explain the situation to the patient and/or his
To Develop Acceptable Attitudes and Values

This includes communication, interpersonal relations with patients, and the development of insight and understanding in patients and himself.

Demonstrated by the student's being able to be open and available for the expression of the patient's experience and needs; understand both overt and latent meanings and messages (listening with the third ear); 'be with' the patient experientially and empathetically, i.e. communicate meaningfully; and support and facilitate the patient's attempts to alter his behaviour or deal with difficult circumstances. He must be able to be aware of personal and professional limitations that interfere with treatment and ask for assistance for these cases if necessary; he must observe confidentiality; show caring concern, that is, make the patient's own and real needs as a person paramount; examine his own behaviour, feelings and motivations, and apply psychological insight to his experience, that is, to develop self-understanding; and recognise that patients have emotional reactions in all medical situations.

He should be able to elicit and deal with emotional and psychological factors in medical practice, and respond to the emotional needs of colleagues and paramedical personnel.

To Participate Actively in Learning Programmes of the Department of Psychiatry

Demonstrated by the student being able to attend lectures, tutorials, demonstrations, etc.; clerk cases carefully and conscientiously, and be involved in the clinical situation; explore the field of psychiatry both within and beyond what is given by means of reading, discussion, experience, etc.; to endeavour to learn for himself; keep an open and inquiring mind; tolerate uncertainty and ambiguity; leave established ideas and positions if untenable; and be willing to think about or solve problems himself, rather than to look for formulae or ready answers.

REFERENCES