Middle Articles

MEDICAL EDUCATION

Teaching Psychiatry in Mental Hospitals*

IAN SKOTTOWE,† M.D., F.R.C.P., D.P.M.

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"Day-to-day responsibility for training their junior staff must remain with individual consultants." These words in a Ministry of Health circular (1964) reaffirm the traditional duty that the head of a clinical firm owes to his juniors in every aspect of medicine. They are particularly apt with regard to the young man, or woman, who joins the staff of a regional board mental hospital as a beginner in psychiatry, because, numbers and circumstances being what they are, this is the setting in which the majority of trainee psychiatrists will receive most of their postgraduate education. The purpose of this discourse is to discuss how this apprentice-and-master relationship can best be developed in the ordinary mental hospital. No one would now claim, however, that apprenticeship alone is enough; and the Ministry's circular encourages regional hospital boards to expand the organization of their training schemes in a more formal way.

Regional Organization

Even before the Ministry's circular appeared many groups of psychiatrists had not been slow to stimulate regional boards to go ahead with training programmes. For example, in 1959 the Education Committee of the Royal Medico-Psychological Association issued a report on this subject; and in 1963 the Troon Conference was held under the auspices of the Department of Psychological Medicine of the University of Glasgow. Our President, Professor Ferguson Rodger, was chairman of that conference; and it was there that our President-Elect, Professor E. Stengel, reviewed the scheme for postgraduate training in the Sheffield Region that he had earlier expounded.

Davies and Shepherd (1964) record a symposium on psychiatric education which was held at the Institute of Psychiatry, the Maudsley Hospital, shortly after the Troon Conference. Among other papers their volume contains a characteristically erudite review by Sir Aubrey Lewis of the history and evolution of psychiatric education as we know it today, which gives perspective to our present efforts. Attention is drawn to the different needs of the metropolis and the provinces. Professor W. H. Trethowan describes developments in the Birmingham Region.

Differences in local circumstances are no hindrance to the practical evolution of realistic training schemes. Examples of diversity are provided by Annear (1965), dealing with training programmes at Morgannwg (a large mental hospital in South Wales), and by D. H. Clark's (personal communication, 1965) outline of the deployment of resources in the neighbourhood of Cambridge.

But the proximity of a medical school is not indispensable. Wessex Regional Hospital Board, under the unique stimulus of having no medical school within its territory, though it has links with medical schools in London, has erected a new building, the Wessex Regional School of Psychiatry, in the grounds of one of its mental hospitals, and has marshalled its teachers almost entirely from hospitals within the Region and the relevant scientific departments of Southampton University. No doubt many other hospitals and regions are developing schemes as yet unpublished. Eventually, all must do so if they are to attract the numbers and quality of junior staff that, with an eye to the future, the specialty needs.

In whatever circumstances they are set up the general pattern of organization of most of these training schemes is as follows: There is a regional centre at which junior members of peripheral hospital staffs attend on a fixed day of each week for lectures, seminars, and the like, during three ten-week terms in the year. A tutor in each peripheral hospital guides the learners in that hospital in their formal studies, looks after the library, and is liaison officer between the periphery and the academic centre of the region. There is also a regional tutor or supervisor at the academic or regional centre. He arranges the formal lectures, demonstrations, and visits to hospitals or special departments, in which all trainees participate; and he helps tutors in peripheral hospitals to co-ordinate their work and time-tables to this end. Finally, there is the ward clinician, the head of the firm to which the beginner belongs. It is upon him that the learner must rely for practical apprenticeship.

The head of the firm is not primarily concerned with guiding his juniors towards passing the D.P.M. or other examinations—that is one of the functions of the tutors—but with training them to be good clinicians. The partnership between chief and junior should have reasonable security of tenure. Senior clinicians vary in the way they apply their clinical methods, and it may confuse a learner if he is transferred from one chief to another too soon. Six months is the minimum desirable duration of a first partnership of this kind—and a year is preferable. A side issue of this is that at present there are still some large hospitals where the clinical firms are distributed topographically into dealing with male or female patients only. I realize that this now obtains only where architectural and other circumstances enforce it; but it is from all other points of view a bad thing, and one hopes it will soon become entirely a thing of the past. Worse still is the topographical division either of firms or of their constituent members into those who deal only with acute and recent patients and those who deal only with chronic patients.

Firms should be distributed not on a topographical but on a functional basis so that they can and do deal with all kinds of patients, men and women, acute and chronic, neurotic and psychotic, inpatients and outpatients, *just as they come*.

* Being the substance of a Maudsley Bequest Lecture delivered at a Quarterly Meeting of the Royal Medico-Psychological Association, London, on 7 February 1966.

† Wessex Regional School of Psychiatry, Knowle Hospital, Fareham, Hampshire.

Without this there is no sure foundation for the realistic, adequate teaching of general clinical psychiatry within a firm.

Organization within the Clinical Firm

The following suggestions are the outcome of my experience of training beginners in an ex-county mental hospital (St. John's, Aylesbury) and in the Warneford Hospital, Oxford, over a total period of some 25 years. While practical arrangements have been modified to meet changing circumstances and an evolving pattern of conditions of service, and should continue to be regarded as flexible, the basic principles are the same today as they were at the start.

I envisage a clinical firm as consisting of a chief, a chief assistant, and two juniors, one of whom is a beginner and the other of whom has had some experience. A man who aims to teach, or learn, psychiatry in a mental hospital cannot do so effectively if he is engaged in a constant struggle against the clock. He must have a sense of orderliness, proportion, and purpose—a clear idea of what he is trying to do in his daily work—and he must resist the temptation to take on more outside work, including committees, conferences, and the like, than he can cope with if his purpose is to be fulfilled. A young beginner in psychiatry needs to learn about life as well as about medical science. He must be given reasonable time to have a personal private life of his own so that he will gradually come to see the relevance of his book-learning to real life and of real life to the problems that are reflected by his patients. This helps him towards the skilful, realistic, and acceptable handling of the patient as a person. For however erudite a man's book-learning or scientific knowledge may be he is unlikely to become a first-rate clinician unless he cultivates a keen perception of other people's feelings and an ability to respond to them appropriately without upsetting the patient, antagonizing the patient, or becoming emotionally involved with the patient.

Granted the prerequisite of sufficient time (another way of saying sufficient staff for a given case-load) the work of the firm should be organized around certain *set occasions* in the week; and only an emergency should excuse any member of the firm from attending them. After these set occasions have been met there is still an adequate residue of time which may be used quite flexibly to deal with more purely "service" demands.

The set occasions are as follows:

Ward Rounds.—There should be at least one, preferably two, full ward rounds a week, when the whole firm visit together all their inpatients. One of these rounds would be leisurely (the tempo of individual patients often sets the pace), and would be used for the demonstration or discussion of *appropriate* clinical points as well as for service purposes. The other can be briefer and for "service" purposes only. The traditional idea of the "grand round" has been criticized recently on the grounds that it embarrasses patients. It need not do so if it is properly managed. In particular, in most mental hospitals there is no difficulty in slipping into a side-room with the patient, so that nothing is said in front of other patients; and it may be appropriate for only one or two members of the firm to take part in this more private brief interview or examination while others deal similarly with another patient, both being discussed by the whole firm subsequently. The overmastering practical advantage of the grand round is that it is the simplest and most reliable means of ensuring that every member of the firm knows the main points about every patient (though only the psychiatrist to whom a patient is allotted will know all the details). There is little risk of misunderstanding or injudiciously conflicting orders about treatment or management; there is the excellent clinical discipline of informed criticism, in either direction; and there is the widest possible range of clinical material for the learner to see and hear discussed.

Outpatient Clinics.—There should be at least one, preferably two, outpatient sessions a week. One of these sessions would specifically include the instruction of one or more juniors, using the clinical material available. The other would be more exclusively for service purposes, and beginners would attend it only after gaining some experience.

Case Reviews.—This is a useful teaching device as well as a technique which has diagnostic and therapeutic value. It is something between a full case conference and a mere passing discussion of a particular point. I first encountered it many years ago when it was being developed by R. G. McInnes at the Warneford Hospital, Oxford. The whole firm plus relevant auxiliaries—for instance, psychologist and social worker—go through the available records, see the patient, clarify the facts of the case, and make up their minds what they are trying to do. I favour having case reviews only on demand, as required, especially when diagnosis is obscure or a plan of treatment seems to stagnate; but any member of the firm may ask for one to clear up a difficulty. In any event, a specific time should be set aside when it is understood case reviews can be held—the morning of the shorter of the two ward rounds is quite a good choice.

Accessibility.—The chief must be routinely accessible to his juniors at an agreed time of each ordinary working day. I suggest that after the ward round is best. (Normally there would be a ward round each day, made by other members of the firm, in addition to the two main weekly rounds which the chief himself conducts.) This is a brief but often a vital encounter. There should also be accessibility in emergency at any time.

Clinical Techniques

The introduction of the beginner to the art of interviewing and handling patients and their relatives should not be left to anyone except the chief. This is an aspect of clinical psychiatry in which experience and maturity count for more than academic erudition.

To begin with the learner should sit in to watch his chief taking a new case, or re-examining an old one. History-taking and interviewing techniques can best be taught in the outpatient department; the demonstration of formal symptoms on re-examination of inpatients. He should be given specific instruction in the requirements of good case-taking, and shown how to elicit the presence or absence of specific symptoms, based on the general idea that the patient's actions and utterances *are* the physical signs of psychiatry. Too often too much is taken for granted. How does one assess the quality of the patient's mood or the presence of thought-disorder? How does one distinguish between hallucinations and obsessions? How does one cross that *pons asinorum* of psychiatric case-taking—the proper examination of the sensorial and intellectual functions? So often there is failure here because the patient gives a superficial impression of clarity or because one is not sufficiently skilled to examine these functions without upsetting the patient, as, for example, in one who is ostensibly highly intelligent, or slightly hostile, or touchy, timid, sensitive, or surly, as the case may be.

The beginner must be taught to record the phenomena of mental disorder as carefully as he would record the physical signs of the cardiac, respiratory, or central nervous systems, and to discipline himself to make his examinations as complete as they should be. Similarly, in history-taking he should be shown not only how to take the history of a psychiatric illness and what special points to have in mind in taking a family history in such a case, but also how to take and record systematically the biography of the patient as a person, including the appraisal, for clinical purposes, of personality, as revealed by the abilities, temperament, traits, and interpersonal relationships of the patient. And he should be shown how to find out, acceptably, the way in which the patient values and deals with such intensely personal matters as religion and sex. This sort of instruction cannot be got solely from books or lectures—it has to be seen and followed and developed as a clinical art. The written word is useful, however, in providing the learner with a schema, that by practice should become second nature to him, within which to record his findings and render them intelligible. I cannot overstate the importance of this aspect of psychiatric education. I have dealt with it in greater detail elsewhere (Skottowe, 1964). Competent case-taking and the writing of

clear, factual case-records that speak for themselves without jargon or expression of theoretical opinion are absolutely fundamental to the sound practice of clinical psychiatry. No one is in a better position to inculcate this art than a student's immediate clinical chief.

Another aspect of clinical work that the chief should himself teach is the beginner's approach to simple eclectic psychotherapy. This may be said to include the right way of formulating to the patient and to his relatives the main findings of the clinical examination and history-taking, and of indicating in a general way what these imply and what one proposes should be done to help. The beginner may sit in at suitably selected psychotherapeutic sessions and after a time may be given selected patients to work on by himself. But he should be required to tell his chief what he is trying to do with his patient, and progress should be supervised, not only by reports and by the chief himself seeing the patient briefly at frequent intervals, but also by an occasional case-review, in which for this purpose only the chief and the learner need be concerned.

A regimen of this kind will give the majority of suitable learners a good foundation for future practice; and it is the main aspect of the teaching that the chief himself need undertake, though he may also elect to introduce the beginner to group therapy and community care, if he himself carries it out. Otherwise the beginner had better learn these techniques from the man who actually practises them.

Chief assistants, senior registrars, registrars, and the like can suitably help to train and instruct the beginner in other aspects of clinical work—for example, the techniques of physical treatments and the proper use and hazards of the many varieties of drugs in common psychiatric use, the management of the patient's daily life, and the right use of occupational therapy and recreation. And they can also expound the subtleties and pitfalls of the various statutory provisions governing the management of appropriate patients.

Conclusion

A beginner who works in a setting such as I have described and who, once a week, attends the more formal set lectures, demonstrations, and seminars at the academic or regional centre, and who gets the feel of children's psychiatry and mental subnormality by prescribed visits to suitable hospitals and clinics, will have had, in two to three years, a sound grounding in general psychiatry. If he is intelligent and industrious he should be able, within that time, to take his D.P.M.; but this is only an incidental, though an important, aspect of teaching psychiatry in mental hospitals. After that he may take up a subspecialty of psychiatry if he wishes to do so.

The larger point is that mental hospital consultants are uniquely placed to provide an indispensable part in teaching a man to become a good clinician. In the course of doing this they themselves are for ever learning. Constant inquisitiveness and reasoned criticism on the part of one's juniors prevent clinical complacency and academic decay. They keep a man on his toes and stimulate him to reach for the sky if he will. They are of immeasurable value. In this subtle sense the learner becomes the teacher and the teacher the learner. May they progress together in a happy symbiosis.

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CONFERENCES AND MEETINGS

Congress of Gastroenterology

[FROM A SPECIAL CORRESPONDENT]

The Third World Congress of Gastroenterology was held in Tokyo between 18 and 24 September under the Presidency of Professor S. KANASHIMA (Japan).

Reviewing intestinal absorption, Dr. A. D. SCHWABE (U.S.A.) presented studies which had used ¹⁴C-labelled glyceryl octanoate administered intraduodenally. Medium-length-chain fatty acids had been found to enter the intestinal cells more readily than longer-chain fatty acids. This correlated with the beneficial effects of giving the former in the diet to patients with malabsorption. Dr. K. OKUDA (Japan), using an isolated intestinal loop, had studied the absorption of ⁵⁷Co-labelled vitamin B₁₂; this entered the jejunum in a non-absorbable form, but was changed chemically or physically by intrinsic factor, and thereby was enabled to pass through the intestinal cell. Dr. MATSUNAGA (Japan) had shown by isotope studies, both in post-operative patients and in animals with various types of intestinal resections and anastomoses, that there was a definite correlation between the amount of small bowel resected and the severity of malabsorption—loss of the middle segment of the small bowel producing the maximal

effects. Dr. RUFFIN (U.S.A.) said that Whipple's disease, which had been previously thought to be a uniformly fatal illness, could now be cured by prolonged antibiotic therapy. He recommended that patients receive 1.2 million units of penicillin and 0.25 g. streptomycin four times daily for 12 days, followed by tetracycline 1 g. daily for one year. He had found that sustained symptomatic improvement occurred, even though serial intestinal biopsies did not show any reduction in the amount of intracellular P.A.S.-staining material or in the degree of lacteal dilatation. Nevertheless, a considerable reduction in the number of viable intracellular bacteria had been found to occur, suggesting they were the cause of the condition. Dr. BURKE (Australia) described the beneficial effects of diets which contained medium-chain triglycerides in children with severe malabsorption states due to liver disease, fibrocystic disease, massive bowel resections, intestinal lymphangiectasia, and alipoproteinaemia. In most instances remarkable improvements had been found to occur. The diet was not yet obtainable in a palatable form, and it was still in short supply. Controlled trials were in progress to

assess it further, and she thought that such diets could have a place in the treatment of adults with similar conditions.

Pancreatitis

In the panel discussion on pancreatitis Dr. DREILING (U.S.A.) reported some investigations into the relation between the liver and pancreas by studying the effect of portacaval shunt on pancreatic function in dogs. The volume, bicarbonate content, and enzyme content of the pancreatic juice had been reduced appreciably by the operation, and he suggested that loss of the alkaline protein-containing pancreatic fluid might be one factor in the production of the peptic ulcers that so often follow these operations. Professor SARLES (France) produced evidence to show that acute pancreatitis was due to gallstones in 45% of cases, to alcohol in 19%, and to other causes—such as corticosteroid drug therapy, diabetes, pregnancy, or pancreatic duct stenosis—in the remainder. Of cases of calcifying chronic pancreatitis 80% were due to alcoholism, and only 2% to the presence of gallstones or to reflux into the pancreatic duct. Rarer causes were chronic