PSYCHIATRY IN THE MEDICAL CURRICULUM*

BY

DENIS HILL, M.B., F.R.C.P., D.P.M.

Professor of Psychiatry, Middlesex Hospital Medical School, London

Since the end of the war, throughout all western countries, there has been profound dissatisfaction with the role of psychiatry in the medical curriculum (Romano, 1950; Hill, 1960; Garmany and Whiteley, 1961; Stengel, 1961; Tredgold, 1962). There has been a steady increase of criticism of the situation in Britain, but such criticism has by no means been confined to the subject of psychiatry alone. It is now generally recognized that the medical curriculum as a whole is far from satisfactory, and it is probable that the specific problems of psychiatry can best be viewed against those of the curriculum as a whole. Medical education and vocational training to be a doctor are now seen to be two roles not necessarily compatible. There are many types of doctor, many types of career, and it is evident that the range of scientific knowledge related to medicine is now so extensive that it cannot be comprehended by one mind. It may be usefully asked, What are the elements in the student's experience which contribute to the acquisition of scientific education? What are the elements which provide him with vocational training for a particular career? and What are the elements which encourage him to become a technician, preoccupied with the acquisition of skills related to the several hundred laboratory investigations which he meets during his sojourn in hospital?

There is indeed a danger that medical education, as a process of teaching the student to reason scientifically, practically ceases when the student obtains his 2nd M.B. As he starts his clinical work he becomes more and more preoccupied with the acquisition of skills and the learning of techniques, too numerous to list here, but all of which have been developed with the object of answering specific questions about the functioning of this or that mechanism in the patient. There is therefore more than a risk that as soon as the student meets the patient technology replaces education. There can be no doubt that this risk will continue to increase. If there is truth in this, then the present training to be a doctor is in no sense vocational, since at no stage is there sufficient time for the student to be taught the business of handling the patient as a person rather than as a series of organs and organ systems. Vocational training has to wait until the pre-registration year, and is then picked up the hard way by practical experience. This may be an exaggerated expression of the situation; nevertheless, in so far as it is true it will mean that the educational process is progressively confined to the pre-clinical years, vocational training to postgraduation, and the most important period of the student's experience—namely, his hospital years—will be given up to the study of techniques and the acquisition of skills related to them.

Two Prerequisites

The success of modern medicine and the astonishing advances of the past 70 years have been based on what can be called the anatomico-pathological concept of disease. In this view disease and illness are the result of pathogenic agents either reaching the patient from outside or developing within him and bringing about dysfunction in various tissues of the body to which in varying degree the body reacts and against which it attempts to defend itself

or to readjust to maintain equilibrium. The conceptual schemata which provide the explanatory hypotheses for understanding are based on strict adherence to the principles of physics and chemistry. For 150 years biological science—and hence medicine—has tried to reach understanding of living phenomena in terms of physics and chemistry, and every endeavour has been made to narrow the concept of biology as a science to the causal-mechanical methods of physics. The dysfunctions of a tissue, an organ, or an organ system when viewed in this way have provided understanding, and medicine has reaped rich dividends; but this concept of disease, when applied widely to the behaviour of the whole individual, has had no success.

As Dr. John Ellis (1962) has written, the days of syndrome medicine are now over: "It is necessary to come to a comprehensive assessment of many variables—expressed in biological, psychological, and social terms." In order to do this two prerequisites are necessary. The first of these, as Dr. Ellis has pointed out, is for the doctor to acquire a scientific method of thought, but, nevertheless, a method of thought which can comprehend human behaviour not only in terms of a biology based on physical and chemical principles but also of a biology incorporating psychological and social phenomena. A secondary prerequisite is, of course, that the student, during his education, should have the opportunity of studying human behaviour from the psychological and sociological points of view. This he is not taught to do during those formative preclinical years when education and scientific methods of thought are offered him.

In various educational programmes the artificial barrier of the 2nd M.B., separating the preclinical period of education from the clinical period of technological instruction, is being attacked. Clinical matters are being introduced into the preclinical subjects, and anatomists, physiologists, and biochemists discuss with their pathologist and clinical colleagues the problems of a given patient in a combined session with students. Many people hold that psychology and sociology are to psychiatry what physiology and chemistry are to internal medicine, and no one can conceive of a medicine taught without the background of its parent disciplines. So far as psychiatry is concerned it is now evident that included in the discipline are two quite different subjects. The first is the traditional study of the mental disorders, the psychoneuroses, and the disorders of personality. The second is the relatively new subject of interpersonal relationships and the ways in which emotional factors, social and cultural differences, and attitudes to role-taking in a variety of human activities influence human behaviour in health and disease. Included in this is the much-discussed question of the doctor-patient relationship and how this influences everything we try to do for patients.

Role of Psychology in the Curriculum

Numerous committees and educational bodies have considered the role of psychology in the curriculum and as yet no clear answer regarding how this subject should be taught has been given. The scheme proposed by Professor Stengel (1961), known as the Sheffield Plan, has been widely acclaimed and has received the approval of the British

*Read at a meeting of the Royal Medico-Psychological Association, London, on November 14, 1962.

Medical Students' Association (1959). As I understand it, this course is called a course on human behaviour and is shared jointly by the psychologists and the psychiatrists. This type of education is offered in a number of medical schools now, but its success would seem to depend on the extent to which what is offered appears to be immediately relevant to real life problems, and on the fact that at Sheffield the preclinical students are introduced to patients with psychosomatic illness and to patients showing anomalies on the borderline between the normal and the abnormal. Thus the transition from psychology to psychological medicine is made without any clear break of continuity. At the other extreme there are the recommendations of the W.H.O. Expert Committee on Mental Health (1961). In their anxiety to introduce psychology and sociology into medical education this committee surely overreached themselves. They recommended a minimum of 40 hours' psychology and 20 hours' sociology. Topics under psychology are listed under 21 heads and would appear to start from three major directions—from McDougall, from Pavlov and Hull, and from Freud. There is an attempt to represent too many points of view and too many different approaches, which can only bewilder the student and frighten his teachers.

Considerable attention should be paid to the teaching of psychology in the preclinical period, because education is more important than the acquisition of techniques, and if the student is not introduced to thinking about psychological phenomena and the individual as a psycho-social organism early in his career and at a time when he is acquiring scientific methods of thought, it will be too late during the clinical period. It is evident that there is a deep cleavage among those who are concerned with psychology applied to medicine, and this cleavage is in part responsible that psychology has not formed a part of the curriculum until recently. There are many difficulties here which have to be considered.

Difficulties in Teaching of Psychology

First there is the cleavage between the psychology which is derived from the study of animals and normal persons and the psychology derived from the study of abnormal persons. The first is carried out by non-medical psychologists working for the most part in non-medical university departments. This psychology has the reputation of being scientific, "academic" in both the best and the worst sense of the word; but it is found by most psychiatrists and clinicians to be of little help to them—that is, it has not yet reached the stage of useful application. The second psychology derived from the study of abnormal persons has been carried out by clinicians, often not working in medical schools or even hospitals, and has the reputation of being unscientific and consisting of a mass of untestable hypotheses. In the public mind, in the student mind, and also in the mind of most psychiatrists and clinicians there is the belief that a state of ideological war exists between the exponents of these two psychologies, which are thought, for reasons that are not entirely evident, to be mutually exclusive—that is, that they both can't be true. Nevertheless, all the reports, in one way or another, suggest that both psychologies ought to be taught.

The second difficulty which confronts the teaching of psychology is the fact that, whatever line or ideology is taken up, it is practically certain to offend or to be unacceptable to at least 30% or more of the students. Whether the student is taught behaviourism and learning theory or whether he is taught psycho-analysis, the facts which he is given and the theories offered to explain the facts are very

likely to be foreign to his way of regarding himself and mankind. This is not entirely a matter of offending religious beliefs and ideas stemming from them, although this certainly is a factor. More important probably is the awareness that principles of determinism which he is able to accept as governing the way things happen in the physical world and also in the biological world, even up to the level of organs and organ systems in his own body, are now being applied to the study of thoughts, wishes, desires, sentiments, and motives which he can observe in his fellows and is aware of in himself. Most students are initially interested in psychology, but may lose that interest, and for a variety of reasons. This new subject comes to the student at what is a most difficult time for him—late adolescence—but to postpone teaching until the clinical period or to make psychology only a postgraduate subject for doctors is to admit defeat.

Aetiology and Teleology

Before considering further the plight of the adolescent preclinical student, another major issue must be mentioned (Hill, 1960). It is concerned with the roles of aetiology and teleology in medicine. Teleology as a way of thinking is privately practised but publicly condemned in medicine as in science generally. The main explanatory hypotheses of medicine are aetiological and rest on physical determinism. Biological events, including human diseases, are determined by a necessary antecedent chain of physical causation. Given a complete knowledge of all relevant antecedent events, human disease and human behaviour become predictable. Thus it may be argued that, given a complete knowledge of conditions, one would have complete knowledge of precisely how a person not only will but indeed *must* behave.

The psychology which implies that by studying the laws which govern the behaviour of the rat we can transfer our knowledge to man produces in the student, particularly in the adolescent student, if he is liable to think beyond the facts, a sense of ideological vertigo in which his conceptions of free will, morality, religious belief, and the immortality of his soul seem threatened. But the psychology derived from Freud serves him no better. For here he is introduced to the idea that the reality which he has been taught is a false one, and that behaviour is governed by unconscious purposes which he cannot identify and of which he is unaware. It is easy for him to resist these ideas which are foreign to everything he has learned hitherto; and indeed he is backed up in this by the majority of his teachers in the physical and biological sciences, as well as by the senior doctors who try to teach him medicine—men and women whom he respects, people he wishes to emulate.

Lastly, then, there is the student himself and his background. It has often been pointed out that the average doctor knows less about human nature, has a lessened capacity for empathic understanding of people, than the average layman, and that his education and training are responsible for this. It has been suggested that medical education involves a process of scotomatization in which the doctor's field of vision is progressively restricted to certain aspects of his patients' functions and lives. This is an inhibitory process, restricting the doctor's curiosity progressively to those aspects of human function with which he feels familiar and with which he has the power to cope. The motivations for this may be complex, but among them is the lessening of anxiety, the maintenance of the traditional myth of the doctor as omniscient and omnipotent, and the doctor's natural desire to help suffering people. If this capacity is seriously and realistically limited, as indeed

it always is, then recognition of only those aspects of suffering for which there should be easy answers is an obvious protection.

It is evident that this process of scotomatization starts much earlier than medical education, that it begins in the home and in the school, and that it is an inherent character of our culture, with its essentially double standards towards reality. Every child has to learn about physical reality and about himself and other humans as people. A scientific approach to physical and biological reality is now accepted even in the nursery, but the child's education about himself as a person and others as persons is not imbued with scientific principles but is based upon traditional myths. On the one hand, there are the religious myths, and on the other there are the morality myths based on the view of the divine or at least immensely valuable quality of human personality, which by acts of will and the exercise of will-power can be rendered either good or bad. At school the mythological view of human personality is maintained by the school culture of rewards and punishments for good and bad behaviour, and by constantly referring the child to historical and literary figures who illustrate the goodness and badness of human nature. It is from this sort of background and from this sort of culture that our adolescent students, newly left school and home, enter their preclinical training to learn anatomy, physiology, biochemistry, and now, it seems, psychology.

The Student

The position for the student entering medicine can be summarized. We have first a culture, deeply and basically biased against the psychological study of man by the same principles of observation and reasoning as are accepted for the study of physical and biological events. We have students emerging from adolescence, having already been subjected to these cultural biases during their most formative years, and, while still imbued with curiosity and intellectual vigour, fearful of uncertainty, seeking facts and having a preference for didactic teaching, and, without being aware of it, seeking training rather than education, certainty rather than the uncertainty which knowledge brings. On the other hand, we have a medicine deeply committed to trying to explain all the ills of man in terms of disorders of physics and chemistry, and indeed a medicine which has shown that the application of the principles of physical determinism has paid rich dividends in the last 50 years. The respected figures in medicine have worked in this field. Until recently it was widely believed that the neurotic and the mentally ill were just poor "constitutional types"—the products of inferior protoplasm who mostly lacked guts and moral sense.

Historically, too, there have been good reasons why the study of psychiatry and psychology has remained outside the medical curriculum until recent times. While for several centuries knowledge based upon observation slowly accumulated concerning physical diseases, observations of human behaviour and knowledge about mental illness could not be made without the overwhelming biases which preconceptions about the nature of mind imposed. Demonology held sway until 150 years ago. Psychiatric patients were never admitted to teaching hospitals. There was little or no contact for students with those who worked in the large old mental hospitals which were built during the last century, mainly outside the main population areas. There were few teachers of psychiatry in the medical schools of Britain until after the first world war, and beds in teaching hospitals for the psychiatric sick are a phenomenon only since the last war—a matter still largely to be corrected.

Psychiatry in Britain too—so long in the grip of neurology—was slower than in the U.S. and on the Continent to recognize emotional factors as determinants of illness. In Britain the influence of neurological thinking and the influence of the German schools of neuropathology and Kraepelinian psychiatry have been far greater than that of Freud. The very success of the anatomico-pathological concept of disease led in Britain to the rapid and successful development of medical specialties, and these have had a profound effect not only upon physical space available in the cramped old teaching hospitals but also upon the available "ideological space"—to coin a phrase. With the rise of each new specialty a place has had to be found for it in the medical curriculum. Each has come to occupy a part of the student's time—and some years ago there was neither space nor time left.

The rise of medical specialties has also encouraged the process of scotomatization referred to above. For each new specialty the student must learn new techniques of examination and investigation. His experience of the clinical period thus leads him to think of a patient as "a heart case," "a neuro case," "an orthopaedic case," and so on. The hospital is seen as a series of special units each dealing with a particular part of the patient. The patient as a person, an individual, is lost among the fragments to which he has been reduced. This has the unfortunate consequence that so long as the student can remain preoccupied with an injured or diseased part of a person he need not experience the full reality of the meaning of illness of the person. He is aided in this by the fact that as a student he remains for practical purposes an observer throughout the clinical period. Only when he ceases to be an observer of what others do and has to take some responsibility for patients as people does he meet the patient as a whole person, and this may very well not happen until his first pre-registration house-job.

From the argument so far developed the conclusion may follow that, so far as psychiatry is concerned, little good can follow upon any attempt to add it to the curriculum as yet another specialty in the present state of overcrowding and congestion. It would seem very necessary to re-examine the subject to see how far it is a separate specialty in medicine, with techniques and methods of investigation of its own, and how much it is a way of thinking and reasoning about patients, incorporating a theory of human behaviour. How much of each of these is it necessary for medical students to learn?

In most schools at the present time psychiatry is given some place in the introductory courses to the clinical period. In these lectures and demonstrations the student is taught how to interview patients, take histories, and examine the mental state. A few demonstrations of the common disorders follow. After this the student may not meet psychiatric teaching until very late in the curriculum, perhaps not until shortly before his Finals. At this time, or perhaps earlier, he attends out-patient clinics, has a short course of clinical lectures, and may have an opportunity to clerk a few cases. The average period of clinical instruction is about six weeks. The psychiatric departments of teaching hospitals have, for the most part, a small staff, few beds, and little teaching-space. Demands for more of all these things are constantly made. It has also been repeatedly said that a longer period of clerking is needed, more time in the curriculum, and time at an earlier period of the student's experience. Finally, a place for psychiatry in the Final examination is constantly asked for. Arguments ranged against these requests are varied but include the following: The students are too immature and young

to be taught these things; or students get too anxious. There is no time left in the curriculum. Psychiatry is a post-graduate subject; psychiatry should not be taught to students but to those in pre-registration house-jobs. Finally, it is said that psychiatry cannot be made a major subject in medical education because psychiatrists do not agree among themselves and no two psychiatrists agree about what to teach.

Objectives

It is necessary to define what the objectives should be. These will necessarily vary from teacher to teacher and from school to school, but the following are given for consideration.

1. There is a need to develop a true medical psychology and to teach it in the preclinical period. Introduction to this should be as early as possible. It is necessary to educate the student in scientific principles as they are found in psychology, but illustrating these only in regard to those aspects which are of direct relevance to medicine. There is a risk of making psychology a dull subject unrelated to the medical reality. A coherent medical psychology can be taught which will include aspects of learning theory, motivation, and individual differences as well as aspects of social psychology and dynamic theories of mental functions. The risk of teaching a total ideology—for example, that psychogenesis explains all—must be avoided. During this preclinical period the student should be brought in contact with people in a variety of circumstances—for example, nursery, school, family, hospital, factory, and prison—and encouraged to draw and verbalize observations.

2. The artificial barrier between the clinical and preclinical periods should be broken down as far as it can be—continuing education into the clinical period and teaching some clinical techniques in the preclinical period.

3. The student must learn as early as possible how to interview patients, and be given far more opportunity than at present to do this. In this he must learn the role of his own personality in the doctor-patient relationship and how his own anxiety and prejudices may affect the way he handles patients and how they react to him. He must at the same time learn to recognize hostility or dependency attitudes in patients and how to remain objective about this. At the same time it is not wise to expose the student to much theoretical psychodynamics, and no attempt should be made to teach formal psychotherapy.

4. The student must come, through adequate opportunity and experience, readily to recognize the role of stress and of personality factors in all illness, particularly in psychosomatic illness.

In considering these first objectives, it is evident that they are not the concern of formal psychiatric instruction. Rather they are aspects of education which every doctor should possess. If one of the purposes of education is to enlarge the student's awareness of human reality and so increase his capacity for control of it, then for all doctors these matters are fundamental. The fact that such education is for the most part at present given by psychiatrists and psychologists is a consequence of our medical culture, which hitherto has deprived the majority of our medical teachers from being educated in these aspects of the human reality themselves. When this has changed, when our medical teachers of the next or succeeding generations are educated to think and reason about patients in psychological terms, and to do so as easily and automatically as they now do in chemical and physiological terms, then this aspect of medical education will no longer present as the great problem it is to-day. Moreover, when this happens there will be no difficulty in reorganizing the curriculum in a realistic way. Perhaps then the most important, if long-term, goal will be to ensure that the medical teachers of the future are themselves educated in these matters.

Clinical Instruction

When the question of how to increase or improve the period of formal clinical instruction in psychiatry is considered two alternatives present. In the first it can be suggested that the period of full-time study in this field should be increased and should be carried out at a more appropriate time in the curriculum. Suggestions vary from increases in time spent from six weeks to six months. At present this is certainly unrealistic, could be introduced only by a radical change in the curriculum, and would be impossible to implement if only because the psychiatric departments of teaching hospitals have too few beds, too few psychiatrists, and are not organized at the level to accept students for such periods. The alternative to such development is that proposed in the Sheffield Plan and complemented by the suggestion which Dr. Tredgold has made for teaching at University College Hospital. In these the period of formal clinical instruction is itself not increased, but the students meet psychiatrists at all stages of the clinical instruction. There is much to be said for such a plan. A simple deployment of psychiatric staff throughout all the clinical departments of the hospital can mean that students, during their clerking in medicine, in surgery, in paediatrics, in gynaecology, and so on, meet psychiatrists at every stage and learn the psychiatric approach to problems which patients present in every department of the hospital. As Professor Stengel has said, this is an exercise in co-operation and calls for the good will, tolerance, and participation of teachers in every field.

Finally, a word should be said about the complex problems of education, technical training, and vocational training. We must admit that the period of medical instruction up to the time of the Final examination is no sort of vocational training for any career in medicine; least of all is it a vocational training for general practice, which the largest group of students finally enter. At present there is no vocational training for general practice, a career which involves the doctor more than any other in the *continuing care* of patients and in which the psychological and personal aspects of their lives cannot be ignored. With the departmentalization of medicine and the progressive differentiation of specialties, the general practitioner remains the only doctor who can view the patient as a whole in relation to his family, his social problems, and his work problems, and he alone has the continuing care of the patient. Vocational training for all the specialties in medicine is provided by periods of postgraduate training and instruction, and during this the student is personally involved in the care of patients and takes progressively more responsibility for them. The general practitioner has no such opportunity. No doubt this issue will soon be faced—but when it is, and when the needs of future general practitioners have been fully assessed and defined, it will be found that psychiatry, in its broadest sense, will have a large part to play.

Summary

Dissatisfaction with the role of psychiatry in the medical curriculum is not confined to this subject. It should be examined against a trend to confine scientific education to the preclinical years, the acquisition of technical skills and knowledge of them to the clinical years, and to postpone vocational training for a career in medicine to post-registration. Fragmentation of medicine into numerous specialties has favoured this process and has made it progressively more difficult for the student to learn about patients

as persons, adapting to an environment. Psychiatry must not, as another specialty, worsen this situation. There are particular difficulties inherent in psychology and psychiatry for the student as well as for his teachers, and among these has been the profound influence of the concept of biology as a science based on the causal-mechanical principles of physics. Resistances within the student and within his teachers to approaching the patient as a person are outlined and the historical and cultural origins of some of these are suggested. Current practice in teaching psychology and

psychiatry is described and an attempt is made to define a series of objectives for the future.

REFERENCES

- British Medical Students' Association (1959). Report on the Teaching of Psychiatry and Psychological Medicine. B.M.A., London.
 Ellis, J. R. (1962). *Middx Hosp. J.*, **62**, 229.
 Garmany, G., and Whiteley, J. S. (1961). *Lancet*, **2**, 38.
 Hill, D. (1960). *Brit. med. J.*, **1**, 917.
 Romano, J. (1950). *J. Amer. med. Ass.*, **143**, 409.
 Stengel, E. (1961). *Lancet*, **2**, 418.
 Tredgold, R. F. (1962). *Ibid.*, **2**, 1344.
 World Health Organization (1961). *Tech. Rep. Ser.*, No. 208.

THE TEACHING OF PSYCHIATRY*

BY

JOHN ELLIS, M.B.E., M.A., M.D., F.R.C.P.

Physician to the London and Prince of Wales's Hospitals; Secretary to the Association for the Study of Medical Education

The medical curriculum has altered much in the past decade. Perhaps the most noticeable change is the very great increase in the amount of time devoted to psychiatry. This subject, both by direct and by indirect means, has grown more extensively in the undergraduate clinical curriculum than has any other, with the possible exception of social medicine. It has not, however, always grown within the teaching hospital itself—and there are some medical schools where the great bulk of this subject is taught by psychiatrists who do not share in the life and work of the medical school, and who do not therefore have any chance of being members of the main teaching team.

This increased emphasis on psychiatry in medical education is a response to a change in medicine. It is difficult to describe, but I suppose it amounts to a new, or perhaps some would claim a revived, interest in the patient as a person, and even as a member of a community. There must now be very few doctors, even in the most mechanical or technical specialties, who think of the patient only as a disease—although, of course, there are many who were never taught to make anything but a disease-label diagnosis, and an organic label at that—and an even larger number whose natural humanitarianism has to operate on less knowledge of human behaviour than many of their patients have obtained from the popular paper-backs.

A New Awareness of Psychiatry

It must surely be true that almost all doctors now accept that there is mental illness as well as physical, and that both are entitled to medical care. A great many doctors now believe that mental disorder may give rise to physical dysfunction, and there is even a steadily growing number who believe that the pathogenesis of every disease has both a mental and a somatic component.

This very remarkable change in the outlook of the medical profession in this country seems to have come about for two reasons. Firstly, there is the advance which has been made in psychiatry itself: arising from the development of theories of dynamic psychology and psychiatry on the one hand; and on the other from the development of neurophysiology, genetics, and other biological sciences, together with the development of the somatic treatment of psychiatric disturbance. Secondly, there is the increase in the obvious need for psychiatric assistance—both to individuals who have difficulty in adjusting to our rapidly changing environment and to society as a whole, which is faced with precisely the same difficulty.

It must, I think, be admitted that the medical profession's new awareness of psychiatry is based much more upon a realization of the need for it than it is upon any belief that this need can effectively be met. Where this view is held by medical teachers it must, to some extent, offset the value of even a greatly increased amount of teaching of psychiatry. This is particularly important because when one comes to analyse educational objectives in relation to psychiatry it is undeniable that the inculcation in the student of proper attitudes towards it is itself the greatest single objective. Of course the acquisition of knowledge and of skill in the subject are also objectives, though exactly what content of each should be offered to the undergraduate is by no means agreed.

The clinical techniques used in the diagnosis of psychiatric problems do not essentially differ, except in the degree of their refinement, from those used in the diagnosis of any other clinical problems, but the therapeutic skills are such that it is difficult to know to what extent they should be practised by the undergraduate. It is very easy to say that the student should learn how to treat neurosis, and that the treatment of psychosis is a subject for the postgraduate training of the psychiatric specialist. This, however, is merely subdividing the treatment of psychiatric problems among doctors, allotting different parts to different branches. Much neurosis may be less disabling than psychosis and its treatment demand less special facilities, but it does not follow that its treatment is easier, or easily taught to an undergraduate student.

Much the same applies to psychiatric knowledge. It may not be very useful for a general practitioner or a general physician to have detailed knowledge of the psychoses, but it may be much easier for a student to acquire a picture of the most flagrant and classical example of the rarest psychosis than to obtain an understanding of the commonest and mildest neurosis.

After all, a greater proportion of psychiatric knowledge is empirical than is the case in many other areas of medicine. It is based on experience, and psychiatrists seem to disagree rather more than other doctors in their interpretation of this experience. Furthermore, this empirical knowledge is not broken down very extensively into little classified syndromes, each with its own symptoms, course, treatment, and label, as so much of the rest of empirical medicine has been. This, I think, is just as well, but it does not make psychiatry any easier to learn.

Attitudes therefore remain more important, more easily defined, and perhaps more realizable as educational objectives in the undergraduate period than knowledge and skill. But attitudes are as dependent on the other clinical

*Abridgment of a paper presented to the Royal Medico-Psychological Association, London, on November 15, 1962.