conduct the superficial psychotherapy which is often all that is required. Of course, the old-style family doctor did this (although often with less awareness of just what he was doing), but undoubtedly the birth of a more truly scientific medicine tended to make doctors sceptical of everything that could not be expressed in terms of physical and laboratory studies. The integration of psychiatry into the medical curriculum is putting an end to the narrow viewpoint.

In addition to being able to handle simple psychiatric problems himself, the new doctor is able to understand the viewpoint of the specialist psychiatrist, and often the latter may be able to see a patient in consultation and then advise the local physician how to handle the problem. The doctor who understands the significance of the child-parent relationship is bound to be in a better position to advise the families under his care, and can thus contribute to preventive psychiatry. There are other long-term advantages to be expected from the programme, but any one of the above points would justify its adoption in the medical undergraduate curriculum.

Examinations

Comprehensive and integrated examinations were introduced at the University of North Carolina School of Medicine in 1955. Students in the clinical years had 1,000 multiple-choice questions to answer. These were based on the types described in the booklet of the National Board of Medical Examiners (1954) and fully described and discussed by Sinclair (1953). All areas of clinical practice were covered by a series of small committees which drew up the questions, and a psychiatrist participated in each committee, as did representatives of all the general and special fields. The result was that, although there was no specific examination from any one viewpoint such as that of surgery or medicine, the total examination more thoroughly searched the student's knowledge than dozens of essay-style examinations could have done. In considering any type of clinical problem the questions involved a real multidisciplinary approach, and the psychiatric viewpoint fell naturally into place. This perhaps was the culmination of the integration of psychiatry.

Students are not examined in psychiatry separately, but are evaluated and graded by the teachers of the small groups in the theoretical and clinical psychiatric courses.

Summary

It seems to be agreed by many that more time is required for the teaching of psychiatry in the undergraduate medical curriculum.

A plea is made for the integration of psychiatry into the general stream of medicine.

The curriculum of an American medical school is described, and the means whereby such an integration is being achieved. The goal is to produce physicians who have a broad scientific awareness, plus understanding and skill in observing their patients with regard to the psychical aspects of aetiology, reaction, and treatment.

It is hoped that such experiences may prove helpful in future planning of the British medical schools.

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TEACHING IN THE GYNAECOLOGICAL OUT-PATIENT DEPARTMENT

BY

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Sir James Spence believed and taught that the out-patient department was the most valuable of the instruments of teaching available to the clinician and that it could best be used to teach the student, by example, the art of consultation. Spence (1949) considered consultation to be the essential unit of medical practice. In his own words, "The real work of a doctor is not an affair of health centres or public clinics or operating theatres or hospital beds. Techniques have their place in medicine but they are not medicine. The essential unit of medical practice is the occasion when, in the intimacy of the consulting-room or sick-room, a person who is ill or believes himself to be ill, seeks the advice of a doctor whom he trusts. This is a consultation, and all else in the practice of medicine derives from it."

Its Form and Purpose

This concept of out-patient teaching stresses the professional relationship and is especially applicable to gynaecology, for great care and tact are required in dealing with patients whose complaints are so often of a personal and intimate nature. With these principles in mind the gynaecological staff of the Royal Victoria Infirmary two years ago reviewed the form and purpose of undergraduate teaching in the out-patient department. Two morning sessions are held a week and up to 30 patients are seen by appointment on each occasion. At these clinics three experienced gynaecologists are in attendance; each takes from two to four students. The patient's history is taken by the gynaecologist with the students seated discreetly in the background acting as observers. The patient is then prepared for examination by a nurse, and one student accompanies the gynaecologist into the examination cubicle. Again the student is largely an observer, but, at the discretion of the member of staff, certain findings may be demonstrated and he may be allowed to palpate the abdomen or make a pelvic examination. In the privacy of the consulting-room, out of the patient's hearing, the case history, findings, and disposal are discussed with the small group of students. During the student's last week in the clinic he is given the opportunity of conducting a few consultations, with the gynaecologist acting as observer. His technique is afterwards discussed freely.

As each new group of students is attached to the gynaecological unit the clinical teaching programme is explained to them. At this preliminary meeting the form of teaching in wards, out-patient clinics, theatres, and tutorial is described, and every effort is made to present an integrated pattern of teaching. Lest the students should consider that this form of out-patient teaching may mean less practical experience for them, it is pointed out that there will be ample opportunity for 'case-history' taking in the course of their work in the gynaecological wards and in the wards of the maternity hospital. Similarly they are reassured that their main experience of pelvic examinations will be obtained in the operating theatre; such examinations as they are allowed to make in the out-patient clinics are essentially to emphasize the need for gentleness.

Discussion

The idealism with which many students begin their medical course is apt to be lost in the hard and constant assimilation of facts in the years of training, and it is surely one of the

aims of the clinical period of the curriculum to help the student regain his sense of service by showing him always an example of kindness, understanding, and humility in the approach to patients. Not all students are gifted with a natural ability to deal easily and sympathetically with people, but, provided they are given the opportunity and encouragement, there is much that they can learn of the art of consultation from their teachers. Most consultations take place in the out-patient department, but the Goodenough Committee (1946), in its report on medical schools, criticized the hurried work and crowded conditions found in the out-patient clinics of many teaching hospitals. The committee did not consider that it was possible, under these circumstances, for the fullest use to be made of out-patient teaching facilities.

In private gynaecological practice, by comparison, the patient attends by appointment, is welcomed by a receptionist, and is seen in privacy in congenial surroundings. Unfortunately the student does not have the opportunity of observing consultations carried out under these favourable circumstances, for it has never been the custom to teach on private patients.

In hospital practice the surroundings and facilities offered by the out-patient department may fall short of this ideal, but in the really important meeting between doctor and patient there is much that can be done to simulate the atmosphere of a private consultation where doctor and patient are left undisturbed and no third party is present to detract from the confidential nature of their talk. With the introduction of a student something of that personal relationship may be lost, but if he can sit in the background as an observer, then there lies the greatest chance that both patient and doctor become unmindful of his presence. That his position as an observer is one of privilege is made clear to the student at the first meeting, when the purpose of out-patient teaching is explained to him.

In many gynaecological units the student is encouraged to take a more active part in the work of the out-patient clinic. For example, he meets the patients and takes the history before she is seen by the gynaecologist. This system has the disadvantage that the student never sees his teacher conduct a proper consultation, for the gynaecologist will most likely listen to the history which the student has taken and then confirm the salient points before the patient is examined. There are disadvantages, too, for the patients. Many are apprehensive when they first attend the clinic; to be met and questioned by an inexperienced student does not inspire confidence, and they are unlikely to disclose to him personal or family worries which may have an important bearing on

their complaints. Unless great care is taken, some patients may even be under the impression that the student is the specialist or his deputy, and this can only lead to confusion. For the patient who is ill, or imagines herself to be ill, the reception she is given in the out-patient department may mean the difference between a satisfactory and helpful consultation and one which is neither.

The surroundings in which the consultation takes place are important for patient and student. The form of teaching which I have described can best be conducted in a small plainly furnished but pleasant consulting-room with an adjacent examination cubicle. The rooms should be so constructed as to ensure complete privacy for each patient. This would seem to be an obvious arrangement, yet it is not unusual to find that patients are interviewed and examined in cubicles separated by thin plasterboard or curtains. A patient may well hear all the details of her neighbour's history, and for some this may be a distressing experience. It is wrong for the student to witness consultations carried out under adverse circumstances, for his own approach to patients and his technique of consultation are likely to be influenced greatly by what he sees in his teaching hospital. Much can be done to modify and rearrange existing accommodation, but the need for new out-patient buildings is particularly urgent in many hospitals. In teaching hospitals, where new clinics are planned, it would be to the advantage of patients, students, and staff if the form of teaching in the various specialties could be discussed fully with the architect.

It is not easy to assess the value of experiments in medical education, for the qualities of a good doctor are difficult to define and measure. In the out-patient teaching described here the staff, by their example, are attempting to show the student that good gynaecological practice is based upon successful consultation. The changed approach to out-patient teaching was instituted two years ago. It has been found to be practicable, and, so far as can be judged from discussion with students and by watching them deal with patients, the experiment has been a success.

I am indebted to Professor H. Evers for permission to publish details of the gynaecological out-patient clinic in the Royal Victoria Infirmary. I should like also to acknowledge my gratitude to the late Professor Sir James Spence for the time and care he took to demonstrate his method of out-patient teaching in the Children's Clinic in the Royal Victoria Infirmary, Newcastle-upon-Tyne.

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SCHOOL VERSUS ACADEMY IN THE MEDICAL CURRICULUM

BY

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The teaching of medical students is a perennial subject, and never out of season. In the last few months the pages of the *British Medical Journal* have carried articles on this subject of weight and great interest (Pickering, 1956; Liebow, 1956; Walshe, 1956), and allusion to points raised in them are made in the present communication. This also deals with the subject of medical education in a broad way; with the relation of the subjects of the curriculum to one another, and especially to the balance of the scientific subjects with those called clinical; and with criticisms, doubts, and questions of medical teaching that are often heard and strongly expressed.

To put all this in historical focus we can take medical history in view from 150 years ago to the present day.

That stretch of time begins with Jenner's discovery of vaccination (1796), a wonderful gift that at one stroke put the dreadful disease smallpox under control; it was followed about 1870 by Lister's work on wound infection that transformed the field of surgery; then by many other fatal infections which became subject to medical control; and to the final mopping-up of the major infections by the moulds and antibiotics about 1940. This is the story of human infections subdued by the science of bacteria, parasites, and viruses. Lastly, we can only mention physiology, chemistry, physics, and pharmacology, all of which made notable advances in the second half of this period of time. All these discoveries of science, of which the above is a bare catalogue, have been made available to mankind by the hospital doctors