REPORT ON MEDICAL EDUCATION

PREFACE

The following report is a summary of a study of psychiatric education by The Committee on Medical Education of the Group for the Advancement of Psychiatry.

The Group for the Advancement of Psychiatry consists of 150 American psychiatrists established in May, 1946, by a mutual agreement to work together. Its purpose does not duplicate that of other professional societies. Rather it is organized as a number of separate working committees, each of which studies one of the major areas in the field of psychiatry, and reports its work to the other members for criticism and approval or disapproval of its conclusions. It is hoped in this way to clarify knowledge, controversy, and policies, in the field of psychiatry for all who are seriously interested in them.

The Committee on Medical Education has devoted three three-day meetings to the problems of this report. In addition it has utilized important studies by other individuals, committees, and organizations, has consulted with experts in other fields of medical education, and has carefully considered suggestions and criticism by all individual members of the Group for the Advancement of Psychiatry.

This report, therefore, represents this Committee’s effort to formulate the function of psychiatry in medical education today, and has been approved by the membership of the Group for the Advancement of Psychiatry.

The Committee on Medical Education presents this material for study and criticism by other psychiatrists, medical educators, and their colleagues in other professions who are active in furthering the modernization and improvement of medical education.

INTRODUCTION

This Committee has undertaken to study psychiatric education at a time when the future of all education has become a matter of serious concern in a society operating under great stress. (See Appendix A). There is a growing conviction that education must be related more pertinently to the society in which we live; that higher education in the words of the President’s Commission on Higher Education for American Democracy, “must be alert to anticipate new social and economic needs and to keep its programs of professional training in step with the requirements of a changing and expanding cultural, social, and economic order.” In medical schools this concern finds expression in the work of innumerable committees set up to revise the curriculum, and in widening recognition of the need for change—thorough-going, penetrating, possibly drastic change—in the techniques of medical education generally. The problem of medical education is not simply to train more doctors, but to train doctors who can help men and women to understand and live with themselves at a time when man’s lack of understanding of himself and his misuse of his own powers has become a threat to civilization.

Modern psychiatry, this Committee believes, is a body of knowledge which can contribute significantly to the reconstruction of medical education. Indeed, of all the fields of medicine, psychiatry has now the greatest responsibility for educational leadership, since it is the most directly concerned with man’s understanding of himself. This was not true when psychiatry was an esoteric specialty devoted chiefly to the diagnosis and care of psychotic and psychopathic patients committed to mental institutions. It has become true as psychiatry has made the study of ideas, fantasies, emotional reactions, behavior, and social adjustments the basis of its empirical interest, and has thereby accumulated fundamental knowledge.

The nature and the extent of this subject is such that it would be impossible for a large group of individuals to agree unanimously on every point. There were minority disagreements, some of which are indicated in this report.

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of the processes by which the human organism adapts, in health and disease, to emotional, physiological, and social stresses.

It is no longer pertinent, therefore, to discuss psychiatric education merely in terms of training for a specialty. It is not even sufficient to discuss psychiatry in terms of the techniques which it can contribute to the practice of medicine. Psychiatry has become a tool by which the basic concepts of medicine (which it is the function of medical education to impart) can be broadened. It is at once an essential part of the science of human biology and a means by which the student's introduction to this science can be facilitated. Modern psychiatry contributes to a more comprehensive knowledge of growth and maturation; of the adaptation of the individual in the family and in society; of the ways in which biological, psychological, and social forces combine to shape human experience and human personality.

To distinguish clearly between psychiatric contributions to general medical education and to the education of psychiatrists as specialists, this report is divided into two parts. The first (see Appendix B) deals with psychiatry's place in the medical school curriculum and in the general internship; the second with graduate training. The specific objectives of undergraduate and postgraduate psychiatric education are to teach the student or physician the significance of emotional experience in health and disease, the meaning and management of the relationship between patient and physician, and the possibilities of medical care which takes account of vital psychological and social factors. The objectives of graduate education are to equip psychiatrists-to-be with the skills necessary for the treatment of the graver disorders of the personality, for productive investigation in this field, and for psychiatric teaching.

As long as psychiatry dealt primarily with the description and classification of the psychoses, regarding etiology and treatment as secondary and minor considerations, it was difficult and relatively unimportant for psychiatrists to maintain close working relationships with teachers in other fields of medicine. This has now become supremely important. But it is not strange that internists, surgeons, and others, still thinking of psychiatry as an isolated specialty, should sometimes be skeptical when the psychiatrist trained to a broader concept of his function offers his collaboration. The greatest difficulty in psychiatric education at present is that there are so few skilled persons—psychiatrists or non-psychiatrists—ready to work intimately with each other as human biologists in medical schools. The psychiatrist who will make the maximum contribution to medical education is one so aware of present and potential interrelationships between different aspects of medicine as to be capable of effective team work in the teaching of human biology and the development of skill in comprehensive medicine.

**UNDERGRADUATE TEACHING**

**Content and Method**

If medical treatment is to become comprehensive, the teaching of medicine, from its very beginning, should be kept as close as possible to the person, the total human being. During his undergraduate years the student should get an orientation of this sort which will last his lifetime. To this end he should see and study people from the first year on. There are psychiatric implications in the care of every patient, and every fraction of clinical experience should be viewed with the broad generalizations of dynamic psychiatry in mind. The special function of the department of psychiatry in this connection is to give the student an understanding of the patient as a person, to give him some knowledge of the techniques necessary for relating himself to the patient so that he arrives at such an understanding, and to develop in him at least some minimum ability to use this knowledge consciously for the patient's benefit, whatever disease or disorder the patient may have.

Teaching should be as non-didactic as possible, centering in the demonstration of actual patients and their biographical histories. The biographical history, with its implications, is the background of all psychiatric teaching, and the early as well as advanced teaching of psychiatry should be related to patients who are seen and heard. Living exposition of personality growth and development, together with evidence of the existence of the unconscious and its dynamics, is indispensable. However, the student should not be given more than he is able to assimilate. There is the danger of exposing him to too much too soon, as well as the danger of too little too late. Great caution is essential in technical discussion involving psychodynamic processes. In the undergraduate years one cannot expect to teach much about the application of the techniques of treatment, but something should be taught of its possibilities.

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1"Postgraduate education" is the education of practicing physicians in psychiatric principles. The Committee is not yet ready to report on this phase of the subject.

2The Committee considers the analysis of autobiographies by the medical students to be an ill-advised psychiatric teaching device. These biographies are done under pressure and superficially, and are often stilted and unnatural in quality. If they are done conscientiously, they involve a degree of introspection which is sometimes very disturbing to the student. In no instance should such material be required unless at least a one-hour personal interview for follow-up can be provided by the psychiatric staff.
positively and negatively, and of the way in which the emotional reactions of the doctor as well as the patient affect a treatment situation. The student's grasp of these matters will not only be of some positive value in helping patients but will tend to prevent the sort of errors in management which occur all too readily when such awareness does not exist.

The primary teaching technique will be history-taking of a different type from that conventionally taught—as far as possible a non-interrogative type requiring for its successful use understanding and acceptance of the concept of medicine already outlined. Students should learn to get an over-all picture of the patient and avoid the tendency to emphasize the presenting symptoms.

Students should have training in interviewing techniques, under close supervision, in each of the four years. They should have ample opportunity to take biographical histories from patients, preferably close to the everyday problems of practice, in the general hospital and outpatient department. One university plans to give opportunity for each student to follow personally, under the guidance of a social agency, the psychological, social, economic, and medical experience of one family through his whole medical course.

Didactic lectures are, on the whole, the least effective devices for teaching psychiatry. Even for large classes, clinical demonstrations are to be preferred to the conventional lecture. In many schools it may be necessary to have the whole student class at the psychiatric sessions, yet a good clinician and teacher can handle this situation by adhering to the policy of teaching from the case—a brief interview with the patient, and then the use of the biographical history to point out principles of personality development, unconscious motivation, and defense mechanisms of the personality, including somatic reactions. In such a process the student is introduced by demonstration to the methods of psychiatric case study.

The greatest need in the psychiatric teaching of undergraduates is access to clinical facilities. It will be seen from what has already been said that the use of patients in the general inpatient and outpatient departments, through cooperation with other teaching divisions, has as much importance as access to the inpatient and outpatient departments of the division of psychiatry itself. Until psychiatric principles and practice are more firmly established in medical college hospitals and outpatient departments, however, it is necessary to use well-selected patient material found in the department of psychiatry. This has some advantages: the over-all preparation of case material in the department of psychiatry will probably furnish a better example to undergraduate students of how cases should be investigated than comparable material from other departments, and the quality of work done in a psychiatric department that has good clinical facilities and is training graduate students will have its effect on undergraduate teaching. But the separation of the psychiatric division from the rest of the hospital and its counterpart, the isolation of psychiatrists (except for occasional consultations) from the general wards, is to be deplored, and teaching psychiatry on the medical and surgical wards is a desirable opportunity to integrate it with other branches of medicine.

If psychiatric teaching is to contribute as much as it can to the task of making better doctors, there is need of curriculum changes involving not only cooperation with other departments of the medical school but also the integration of psychiatry with the teaching of the social sciences and the humanities elsewhere in the university. In the medical curriculum more hours should be assigned for the teaching of psychiatry, but the Committee does not favor increasing the number of hours given to psychiatry to a percentage equaling or approximating the incidence of psychiatric problems in practice, which might bring them up to as much as 60 per cent of the entire curriculum. It is recommended that there be a total of approximately 370 hours for psychiatry, 60 in the first year, 60 in the second, and 250 during the third and fourth years. This allotment is not theoretically adequate, but is certainly a considerable increase over that existing in most medical schools today. Probably there has been too much ado about the number of curriculum hours devoted to psychiatry, particularly in the so-called preclinical years. The bottleneck precluding the use of more hours than those suggested here is a deficient supply of competent teachers. It would be dangerous for the department of psychiatry, even on invitation, to take on more teaching time than it can use well.

Preclinical Courses. In the preclinical years it is suggested that half the time allotted to psychiatry be given to actual experience in elementary interviewing of patients and half to psychological and theoretical courses. While it is sometimes possible to correlate the basic course in psychiatry with other basic science courses—anatomy, physiology, chemistry, and pharmacology—the majority of the Committee considers that basic psychiatry has developed to a point where it is a basic science and cannot be taught entirely by such correlations. Even in the preclinical years seminar instruction is preferable to lectures, and if it is possible to split the class into sections (10 to 15 students each) this should be done, the work of the sections being coordinated by frequent conferences between the head of the department and his section
leaders.

First-Year Teaching. The introductory course should deal with personality growth and development and the defenses of the personality. This course should be given in the first year, preferably beginning early and spread throughout the year, with a minimum of one hour per week; two hours per week are desirable. It should include some training in clinical psychology. Teaching should center about actual cases with demonstration of the patient and his biographical history. There is need of a good text for this phase of psychiatric teaching.

The majority of the Committee is opposed to demonstrating psychotic patients in the introductory course, on the ground that such case material is too bizarre and too far removed from the student's own life experience. The student's development of empathy with the patient is an important aspect of the learning process; this comes about more easily when the patient's reactions are less extreme.

The majority of the Committee believes that students should have an opportunity to take biographical histories from a few non-psychotic patients during the first year, and that this experience should begin early in the year. The minimum time recommended for this work is ten hours, or as an alternative sufficient time for interviewing at least ten patients.

At the end of the introductory or first-year course, the student should know that psychiatry deals with the study of the personality; that emotional conflict and environmental stress give rise to physical, mental, and social problems; and that unconscious motivation is a reality. He should be familiar with the natural history of normal personality growth and development; the nature of conflict; the defense reactions of the personality; medical and social factors in adaptation; and the existence of interpersonal feelings in a valid doctor-patient relationship.

Second-Year Teaching. In the second year, teaching should deepen the knowledge gained in the first year and should include instruction in psychopathology. There should be continued emphasis on the principles of interviewing, and personal experience in interviewing at least ten patients. The patients should be drawn from the psychiatric outpatient department and other services, but should not include psychiatric

inpatients of a psychotic type. Good examples of psychoneuroses can be found in inpatient services. Leading more specifically than the work of the first year into the dynamics of psychopathology and reaction syndromes, this course should prepare the student to enter upon his clinical years with a working knowledge of personality, the doctor-patient relationship, some of the clinical syndromes, and the possibilities of therapy. For the more formal instruction, clinical demonstrations rather than the conventional lecture are essential, and the division of the class into small groups is much to be desired.

The Clinical Years. For the third and fourth years together the minimal time recommended is 250 hours, to be spent chiefly in the outpatient psychiatric clinic and general medical and surgical services. This time is needed for psychiatry, not for training in a specialty, but for comprehension of a basic medical discipline.

The third and fourth years should be intensely clinical. There should be one instructor to supervise every two students, and ample time for the discussion of clinical assignments. In these years the special need is to stress the development of skills in interviewing and the use of the doctor-patient or student-patient relationship as an effective therapeutic instrument. Seventy-five per cent of the time should be spent with the kind of patients the student will see as a physician in non-psychiatric practice; the remaining 25 per cent should be spent with psychotic patients, and psychotic material should be studied in both clinical years. It is necessary for the student to learn to recognize the psychotic syndromes and to become acquainted with general methods for their management.

Instruction should include the early recognition of central nervous system disorders, geriatric problems, and problems of the chronically ill; the criteria for distinguishing neuroses and early depressions; the recognition of the early signs of schizophrenia; the identification of paranoid states; the nature of delirium as seen in general practice; the psychiatric aspects of anoxia and head injury. The evidences of illness are relatively clear in these cases. Most of the work with psychiatric inpatients may be done in the third year; outpatient work should be emphasized in the fourth year. The student had his introduction to psychotherapeutic principles in his first year; these principles will assume increasing importance to him as he gains experience with ambulatory case work in the fourth year.

The General Internship. The considerations that make psychiatric teaching essential for the undergraduate of medicine apply with equal force in the general internship. Most general hospitals at which
internships are taken do not have psychiatrists in regular attendance as consultants, but every year the number of psychiatric services in such hospitals increases. In a few general hospitals, particularly those in large cities and those connected with medical schools, interns are rotated through the psychiatric division. It would improve the training of interns in general hospitals if some of the specialty examining boards in other specialties than psychiatry—particularly in internal medicine and pediatrics—took official cognizance of psychiatry as a necessary part of the training of their candidates. The Committee believes that all physicians going into internal medicine or pediatrics should have at least six months' training in psychiatry. In view of the large psychiatric component in the practice of medicine, more questions testing the students' knowledge of psychiatry should be included in state and national board examinations.

The Teaching Situation

Thus far this report has been concerned with recommendations for a program of psychiatric teaching in the undergraduate and general intern years. The setting in which such teaching is done must now be considered. Students come to medical schools with innate personality characteristics, which have been influenced by a largely standardized routine of premedical education. They submit themselves to a body of faculty members of diverse medical and scientific interests and personal predispositions, acting under the governance of a medical college administration which allocates time for instruction, provides material and clinical facilities, and approves or authorizes the methods of instruction used.

The Premedical Curriculum. The reforms in medical education of 40 years ago led to a system of premedical requirements in the laboratory sciences which today excludes students of more general cultural orientation and psychological interest from medical schools. There has been a tendency to lose sight of the value of humanistic studies, particularly the classics. Premedical students and instructors in the premedical courses are apparently of the opinion that additional credit in the laboratory sciences, beyond the stated requirements, may help a student gain admission to a medical college. This view should be discouraged. There should be more emphasis placed on the social sciences and the humanities as prerequisites for admission, and social and environmental medicine might well be taught the undergraduate in the medical school itself.

The value of psychology as a premedical subject is determined in large measure by the clinical orientation of the teaching staff. Usually this is lacking. Academic psychology is of little value for our purposes, and the adequacy of preparation of psychologists for this assignment is questionable. Courses in psychology given in the premedical college years are spotty; a few are good, most are mediocre, and some are positively bad. Possibly an elementary course in psychiatry, rather than the so-called abnormal psychology, should be taught in the premedical years. Universities would probably welcome some guidance about what should be taught in premedical psychology courses.

The Students. Many more students apply for admission to medical colleges than can be accepted. It is reported that in one recent year there were 1,000 candidates for 75 places at one medical school. It is important to select students carefully, but the Committee has come to the conclusion that there are no reliable techniques for determining the suitability or unsuitability of applicants.

Exact information as to the inclusion of psychiatrists on admissions committees is not available; it is not a general practice. The Committee feels that a psychiatrist should serve on the admissions committee. His special qualifications should be used as much as possible, particularly in cases in which personality characteristics are in question. The Committee recognizes the unwisdom of insisting that all candidates in medicine be especially sensitive to human relationships, since there are multiple motivations in the choice of medicine as a career, and many areas in the field of medicine in which such sensitivity is not necessarily requisite.

The inherent interest of students in psychiatry is affected by various factors. In the first year students often express a strong interest in it. One year at a mid-west university 55 per cent of the students entering the medical course stated that psychiatry was the specialty they wished to follow. While percentages reported from other schools are not so high, there does seem to be a significant change from the attitudes familiar in the past. Yet even those students who are interested when they come are subject to counter-trends in the medical school, and those who have a little interest of their own are easily prejudiced against psychiatry. Lack of initial interest in psychiatry, uncomplicated by such influences,

6Physicians who intend to specialize in psychiatry do not need the psychiatric training offered in these hospitals, though they often seek it.

7In some instances, of course, such interest is not necessarily a good thing; persons intending to specialize in psychiatry deserve careful scrutiny.

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should not materially hamper good teaching.

Psychiatrists should give serious attention to medical students as persons as well as future physicians. In psychiatric education we are trying to change the student's inner self, and through this change to enable him to do better work with his patients. This is much more than giving him techniques which he can use in practice. He has biases—conscious and unconscious. Ordinary medical education tends to set these biases very early. This makes it extremely important to start psychiatric teaching at the very beginning of the medical course.

A good working relationship between student and instructor is important. When students cannot ventilate their confusions and get some clarification, they feel frustrated and may reject what is offered for their education. This may block their ability to develop empathy with the patient, which has been mentioned as an important aspect of the learning process. Medical students often require individual help with their own problems of adjustment. If students come to us, their teachers, we should either give them immediate assistance or refer them to someone else if they need more extensive help. Student health services should give adequate recognition to the fact that students need such help.

The Faculty. Present difficulties in the way of undergraduate psychiatric education arise more often from the system of medical education and the attitudes of other members of the faculty than from lack of interest on the part of students. Many members of the faculty had an undergraduate training in which psychiatry, if included at all, was taught as a minor specialty. It would be too much to expect that any considerable number of these men, however eminent in their own fields, would have had the opportunity, the interest, and the time to make up for this deficiency to the extent of ready accepting the concept of psychiatry as a basic science. Faculty resistances are due partly to lack of understanding of the role of psychiatry, partly to the precedence which each man accords to his own work, especially when he is in competition with others for teaching time in the curriculum and for facilities for doing his work. These resistances seem to be diminishing, and aggressive methods to effect a change might do more harm than good. Resistance on the part of other members of the medical faculty will have to be overcome by demonstrating the value of psychiatry.

The problem involves more than stirring interest and developing an initial preliminary conviction in the non-psychiatrist by a sharing of clinical demonstrations. There is real danger that subsequently these other teachers who have become interested in psychiatry may begin to feel inadequate in their own fields. They become aware that many of the patients they have dealt with needed a kind of care they have been unable to give. This may be seriously disturbing. The psychiatrist needs a close understanding with the heads of other departments and support from the top to weather the period in which other teachers develop insecurity. The rapport which is more easily created with the younger men in the department makes the psychiatrist less vulnerable with them than with older men. The psychiatric staff should be well aware of what is going on in other departments of the medical school and should use every opportunity to collaborate with them. Psychiatrists in general do not associate enough with men in other specialties.

Teachers of psychiatry also deserve some comment. There may be too much emphasis on what is being taught and too little on who is doing the teaching. It is not to be expected that the poor teacher will be improved solely by training in method, and good methods of teaching become truly effective only through the offices of a good teacher. The good teacher will be capable of recognizing the general value of good methods, but he will undoubtedly develop his own technique in using such methods, and he will be capable of making well-controlled methodological experiments. Latitude should be given such a teacher in choosing his own methods.

There is question whether ability in teaching is given sufficient weight in the selection of the medical faculty. Too little attention has been given to the training of teachers in medicine generally and in psychiatry in particular. Criteria should be set up for minimum training and minimum experience for competency as a teacher of psychiatry. For example, training for this purpose should not be considered well-rounded unless it includes a very substantial practical experience in the psychiatrist-social worker-psychologist team and experience in the individual tutorial relationship. We need a greater number of competent teachers to implement a good psychiatric program and funds to support them. It has been stated that the doctor has the shortest earning span of any professional member of the community, and the psychiatrist, the shortest earning span of all doctors. As we insist that standards be raised, therefore, we should also be uncompromising about the salaries that teachers of psychiatry should get.

The personality factors that are characteristic of a good psychotherapist seem to be characteristic also of a good teacher of psychiatry. However, such a

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9See also the discussion of Graduate Education which follows.
teacher should work under conditions which will enable him to function at his best. The psychiatrists available today, limited in number, are asked to extend themselves to the point where they cannot manage to do a good job in any one field.

**GRADUATE EDUCATION**

**Content and Method**

The foregoing discussion has underscored the pressing need for psychiatrists to carry into comprehensive medicine the fundamental contribution which psychiatry can make in the undergraduate and general intern years. The need for psychiatrists in practice, in specialty teaching, and in investigation is no less acute. The function of graduate teaching is to provide fully trained psychiatrists.

While progressive psychiatrists are pretty well united in their thinking about the objectives and general content of graduate training, it would be disastrous if all psychiatrists trained all their men in the same way. The purpose of graduate training cannot be achieved by any specific and routinized type of teaching, and in discussing this phase of psychiatric education the Committee accordingly confines itself in the main to general principles.

The emphasis during the residency training program should be upon individual therapy, and the tutorial relationship is the best single method of teaching. In general there should be a progression of experience in this relationship. The initial phase of training should allow for intensive opportunity for observation over a considerable period of time but with relatively few patients. After this a greater number of patients should be seen less intensively. Next, there should be participation in continuous supervised therapeutic seminars. Then there should be supervised individual therapy. The case load for residents should not exceed twelve patients and preferably should be less. At least half a day, five days a week for a period of three months should be given to clinical experience with children.

There may be considerable latitude in setting up the actual sequence of these experiences, and it matters little whether the patients the student starts with have a psychotic or a psychoneurotic reaction. It is essential, however, that students have adequate opportunity to get experience in the use of psychotherapy. They cannot do so if shock therapy replaces almost all other methods of treatment. The wholesale use of shock procedures in training centers defeats the very thing we are after, i.e., training in dynamic psychiatry.

Opportunity should also be given for thorough experience in both consultation and treatment in the general hospital inpatient and outpatient services, and in the handling of children’s problems, preferably through the establishment of good teaching and treatment relationships with the department of pediatrics. In some centers (but not yet in many) the latter will be facilitated by special pediatric-psychiatric units.

The essential purpose of the psychiatric hospital is to serve the community, and getting related to the community is an important part of the student’s training experience. The graduate student needs to go beyond the consulting room and the hospital and to have first-hand experience with the patient in his own setting, as for example by making home visits. Here a relationship with psychiatric social work will be great advantage. This is one of several ancillary areas in which the student should have training. Students, residents, and interns also all need instruction in psychiatric nursing techniques. It is imperative that some training in psychology and social service be included at the graduate level. Residents as well as medical students could learn much from social workers regarding community resources. Participation in some of the methodology and training of the psychiatric social worker is a valuable element in the preparation of a psychiatrist, and the association is mutually profitable. Approximately six months of training in cooperation with psychiatric social workers and psychologists, with substantial experience in the psychiatrist-social worker-psychologist team, are needed to give residents at least the minimum of the experience they should have. There should also be opportunity for a brief period of orientation in the diagnosis, training, care, and rehabilitation of mental defectives and of juvenile delinquents.

As to basic courses of instruction, the suggested requirements of the American Board of Psychiatry and Neurology call for neuroanatomy, neuropathology, neurophysiology, neurorontgenology, clinical neurology, psychopathology, psychobiology, and clinical psychiatry in a present-day training program of three years’ length. (See Appendix C.) Teaching should also include an orientation of the student to the historical development of psychiatric knowledge. There is need to stress medical sociology—the social interrelationships of the patient in his environment—and to give the student a knowledge of the relationship of psychiatry to cultural history and anthropology, with emphasis on the manifestations of our own culture.10

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10While it is often stated that lectures have little or no place in graduate training, there are conditions under which more lectures could be used effectively. The nature of the particular subject matter to be taught, the number of trainees in a teaching center, and the skill and fitness of the teacher in the use of this method are the chief factors which determine the advisability of the use of lectures. The seminar results in more personalized training.
Before a candidate becomes eligible for certification in psychiatry by the American Board, a minimum of five years must elapse after the completion of an internship. Three years of this time must be spent in training as a resident in psychiatry. Out of the minimal residency period, the Committee believes that six months should be spent on neurological and allied topics; six months might be spent in the study and treatment of the serious psychotic conditions met in a disturbed or closed ward; but the remainder, whether twelve months in a two-year program or two years out of a three-year program, had best be devoted to the study of the psychoneuroses, the less disturbed psychotic states, psychosomatic states, mental deficiencies and juvenile delinquency, and the less sweeping reactions, in both an inpatient and outpatient setting.

In general the Committee based its discussions on a minimum residency training period of three years. However, one, two, and three year residencies are approved by the recognizing agencies and it is not to be expected that the shorter residencies can be or should be proportionately reduced models of the full three-year program as to content.11

In the opinion of the Committee, a personal analysis and thorough psychoanalytic training are valuable but should remain optional in the training of the psychiatrist. Members of the committee hold various opinions as to the role of psychoanalytic training in the teaching program of the graduate student and the time when it should be given. One group maintains that psychoanalytic training should not be the major phase of the training program and that caution should be taken to introduce it when the student is mature enough to benefit most from it. There is danger is becoming too dogmatic about the time schedule. In the current stage of training and in the hands of seasoned trainers individualization is indicated; there are no general rules. When the student has had little or no exposure to dynamic concepts it may be desirable to start an analysis earlier than otherwise. In any event, the total training program must lead to a fundamental understanding of the emotional growth and development of the individual—whether patient or student, and whether this understanding is secured by means of a personal psychoanalysis or by some other means.

When one teaches another he teaches himself. Therapeutic experience and teaching skill are closely related. The graduate student should assume some responsibility for teaching, and training in methods of teaching should be given him. He should participate in undergraduate teaching and in the teaching of psychiatry to nurses.

It is a serious question whether in ordinary graduate training a student should engage in investigative work. Certainly caution is needed in encouraging graduate students to participate in investigation before they have acquired a working knowledge of the methods and techniques of research. It might be well to organize a society for young investigators in this field comparable to the American Society for Clinical Investigation.

The Committee sees no need of assigning required reading to graduate students. Presumably students of sufficient maturity to do graduate work will seek out the reading they need. A journal club meeting once a week might prove a medium for exchange and a stimulus to do some reading of the current literature. (See Appendix D.)

The ultimate objective of graduate teaching is to add to all that has been discussed thus far under the head of undergraduate education a working knowledge of the interrelations between the phenomenology of disease and its underlying unconscious significance. This involves the development of skill in the tracing of the dynamics of human behavior and in their manipulation by psychotherapy and other methods of treatment. Training should give opportunity for developing teaching skill, and should furnish some acquaintance with research, particularly in the areas of overlapping disciplines such as pharmacology, physiology, chemistry, and psychology.

The Teaching Situation

The Candidates. There is general agreement that candidates for graduate training in psychiatry should be fundamentally honest persons with some understanding of their own emotional structure. There should be very careful consideration of any candidate with serious personality disorder. But there seem to be no exact quantitative methods for testing the desirable attributes. Review of a study of this subject made elsewhere by a questionnaire sent to outstanding analysts indicates that there is no unanimity.
of agreement as to any factor of paramount importance. Practically every kind of personality consideration was mentioned by one or more of the correspondents. Since the men chosen for psychiatric training will be the teachers of the psychiatrists of the future, the responsibility resting upon those who choose them is great. The Committee suggests further study of the profession to see if it is possible to come to more objective conclusions as to the type of man who should be taught psychiatry.

The Faculty. The teacher of psychiatry should have special ability to communicate clearly and to create interest and enthusiasm. He should have as broad a clinical experience as possible, and a reasonable grasp of the methods of ancillary fields. Skill in therapeutic technique is of importance in a teacher: it may not be sufficient by itself to make a teacher, but essentially all training in this field will have to be centered around therapy of patients. A considerable number of people in private practice, not necessarily connected with universities, have extensive experience and skill in therapy. It is possible that some of these could and should be drawn into the teaching program at this point, particularly into the program of the Veterans Administration. In view of the danger of provincialism in learning all one's knowledge from one instructor, the Committee suggests that the student have an opportunity to learn from more than one individual. Visits of professors to other clinics than their own may be some protection against insularity and provincialism and may help to acquaint them with methods of teaching better than those they are now using.

The personality of the professor is important in psychiatric teaching. The student's work with the patient is the subject of intimate, continuous, and repetitive supervision in individual seminars and conferences. Between the graduate student and his supervising teacher there thus develops a peculiarly intimate relationship, with possibilities for strong identification with good teachers.

A Plan for the Present Emergency. In the next ten years the facilities of medical colleges, hospitals—state, veterans, and private—and clinics and institutions will be taxed to the limit to meet the need for the training of psychiatrists. During this time the difficulties will be multiplied by certain current factors: medical school enrollments are falling off; the normal professional maturation of doctors has been impeded by the war; many students from countries no longer able to continue or develop their own programs will seek training here; and the increased cost of living will limit the number of Americans able to take the necessary training. It may be that the best that can be done under existing conditions will fall short of the need; that major modifications in the present system of medical education may become necessary.

One such modification has been offered for discussion by a member of the Committee. Its purpose is two-fold: (1) to train more qualified specialists at an earlier age and in a shorter time than by the present method, and (2) to develop a program of instruction in the undergraduate years which would serve as an example and tool for establishing psychiatry in its true role in medical practice. The plan is essentially to establish a curriculum within the medical school leading to the degree of Doctor of Psychiatry or Doctor of Medicine in Psychiatry. Present courses would be reduced by 25 per cent to 40 per cent of their present hours and the time thus released would be used for concurrent study of psychiatry as a specialty. Thus psychiatrists would be trained at the undergraduate level. The proposer recognized that such a plan would encounter practical obstacles in the curriculum and traditions of medical schools, and in the regulations governing licensure, but he did not consider these insuperable.12

There may well be need to reform a system under which the psychiatrist waits six years after graduation from college to begin the intensive study of data which lie at the heart of his profession. But the general opinion of the Committee is that modifications of the curriculum at both graduate and undergraduate levels will have to be made on a realistic basis within the familiar structure of medical education.

CONCLUSIONS

Undergraduate Education and the General Internship

1. Psychiatry has a basic contribution to make to the biology of human adaptation and to the teaching in all departments of medicine. It should therefore be taught throughout the medical course, not as a specialty, but as an integral part of medical science and medical practice.

2. The objectives of psychiatric education in medical schools are to develop the student's awareness of emotional experience in health and disease, the emotional factors in the relationship between patient and physician and its management, and the possibilities of comprehensive medical care.

12Similar proposals, differing in detail but based on the same principles, were made by others at the Conference on Clinical Psychology of the Josiah Macy, Jr., Foundation, March 23-27, 1947.
3. To attain these objectives there must be close cooperation between departments of psychiatry and other departments. Hindrances to such cooperation should be resolved.

4. Teaching should center in the patient and his psycho-social development. Theoretical teaching should be minimized; clinical teaching and practical experience in interviewing should be emphasized. From the beginning of his course the student should have supervised experience in interviewing patients.

5. Patients for pre-clinical psychiatric teaching should be selected in large part, whenever possible, from the general inpatient and outpatient services of the teaching hospital.

6. The curricular hours in psychiatry should be increased to approximately 370 hours, provided there are a sufficient number of competent teachers to use this time effectively.

7. Instruction of first-year students should be oriented to aspects of normal experience with which the student can easily identify, including normal personality development, the nature of conflict, adaptive mechanisms, the significance of the doctor-patient relationship, and the elementary principles of interviewing.

8. Instruction of second-year students should focus on the principles of psychopathology, the psychology of the doctor-patient relationship, the dynamics of emotion and its relation to physiological and social processes, and the techniques of interviewing.

9. Instruction in the third and fourth years should center in clinical work under close supervision. Three-quarters of the time should be given to emotional problems common in general practice, one-quarter to the study of psychiatric inpatients.

10. A plan for giving each student opportunity to follow the experience of one family throughout his undergraduate course is recommended for trial as a teaching device.

11. The general internship should include experience on a psychiatric service. Physicians going into internal medicine or pediatrics should have at least six months' training in psychiatry.

12. The laboratory sciences have been too long over-emphasized as premedical requisites.

13. Psychiatrists should be represented on the boards which select students for admission to medical schools. More research studies might contribute to selection skill.

14. Psychiatric help should be available to medical students needing it.

**Graduate (Specialty) Training**

1. Graduate training should center in the maximal attainment of understanding of the basic principles of modern dynamic psychiatry and their phenomenology and application in clinical work. Clinical experience should include work in the general inpatient and outpatient services as well as the psychiatric services and should include extensive work with children. It should take the student into the community.

2. Training in psychiatry should give the student a working knowledge of psychology, psychiatric social work, and psychiatric nursing, and should include substantial experience in the psychiatrist-social worker-psychologist team.

3. In addition to meeting the specific requirements of the American Board of Psychiatry and Neurology, instruction should acquaint the student with medical sociology, cultural anthropology, and the history of psychiatry.

4. During a minimal residency period of three years, six months should be spent on neurology and allied subjects, six months in the study of severe psychoses, the rest in the study of psychoneuroses, psychosomatic disease, non-incapacitating emotional disorders, mental deficiencies, and juvenile delinquency.

5. A personal analysis and thorough psychoanalytic training are valuable, but should remain optional in the training of the psychiatrist. These should conform to the requirements of the American Psychoanalytic Association.

6. Experience in teaching is an important part of psychiatric training.

7. The ultimate objective of such training is to give the psychiatrist a working knowledge of the interrelations between the phenomenology of disease and its unconscious significance, with skill in the tracing of the dynamics of human behavior and their manipulation by psychotherapy and other methods of treatment.
8. Methods of selecting both graduate students and their teachers should be more carefully studied.

9. The training of psychiatrists cannot be standardized. Variations in curricula are highly desirable.

10. The need for well trained modern psychiatrists in practice, in teaching, and in research is acute.

**DISTRIBUTION OF THIS REPORT:**

American Psychiatric Association

President or Chairman of Lay Governing Boards of Medical Schools of United States and Canada

Deans, Professors of Psychiatry, Professors of Medicine of Medical Schools of United States and Canada

Chiefs of Service of Hospitals providing Psychiatric Residencies

Chairmen of Specialty Examining Boards

Group for the Advancement of Psychiatry

**APPENDIX A**

I. Review of work done by American Psychiatric Association Committee on Psychiatry in Medical Education (Undergraduate Education of the Medical Student)

The accomplishments of the Committee during the past decade were:

(1) Improved psychiatry in medical education through the establishment of the teaching of psychiatry in each year of the four-year course. Thirty-five schools have added courses to their preclinical curriculum, Clerkships and outpatient teaching and the furthering of the organization of liaison psychiatry in the clinical years have been developed.

(2) Aiding in the formation of the American Board of Psychiatry.

(3) Acceptance and establishment of the basic three-year residency as well as recommendations for providing psychiatric experience during the internship.

(4) Efforts toward improved standards whereby state hospitals would serve as teaching and research centers.

(5) Participation in four conferences on psychiatric education, and in the work of the Committee on Graduate Education in 1940 and on the Advisory Council on Medical Education.

(6) The conduction of five two-week institutes held in widely separated parts of the country in 1940-42.

(7) The preparation of a neuropathological slide collection and atlas of state hospital physicians and candidates for the board examinations.

(8) Advice to deans and medical students checking the trends toward the development of separate departments of psychosomatic medicine. Qualifications for the training and selection of teachers were promulgated.

(9) Unsuccessful attempts were made to have psychiatric representation on the National Board of Medical Examiners, and to include more psychiatric questions in its examination. Likewise efforts were made by the committee to have psychiatric questions in examinations for state licensure.


II. What is being taught in psychiatry in our approved medical schools:

Following are approximate results of a questionnaire sent by the Chairman, Committee on Medical Education of the A. P. A. to department heads of 69 four-year schools in the United States and 9 Canadian schools:

**Psychiatry taught:**

- As a Specialty                      8 schools
- As a Basic Science                 35 schools
- Both                               8 schools
- No answer                          7 schools

**Analysis of Teaching Content Indicates:**

- No instruction given in first year 12 schools
- In first and second year           1 school
- In second year                     1 school
- In second and fourth years         2 schools
- In third year                      1 school
- In fourth year                     1 school

**Adequate clinic-team relationship**

- 28 schools

**Rehabilitation service planned or in operation**

- 11 schools

**Student assigned to family**

- 5 schools

**Lack of true appreciation of psychiatry by members of faculty**

- 4 schools

**Adequate finances**

- 16 schools

**Research funds available**

- 17 schools

**Separate department of psychiatry**

- 38 schools

**One or more full-time teachers**

- 28 schools

**No full-time teachers**

- 30 schools

**Psychiatric Liaison department**

- 17 schools

**Teaching hours average**

- 75 didactic hours per school and
- 77 clerkship teaching hours
- total 152 teaching hours

This terse summary indicates to some extent the present status of undergraduate teaching of psychiatry. In contrast to the survey of teaching in medical schools in 1931-32, it shows many progressive changes, summarized briefly as follows:

1. There is greater acceptance of the presentation of psychiatry as a basic science.
2. Psychiatric liaison divisions in medical schools have doubled.
3. Time actually spent in teaching psychiatry has also approximately doubled—from 77 to 152 hours.
4. Outpatient and clerkship teaching, although woefully inadequate, have been added to the curriculum in more schools.
5. The concept of the clinic-team social service worker, psychologist, and psychiatrist, in contrast to the 1932 survey, apparently has been developed in 28 schools.
6. More schools now are utilizing full-time teachers.
APPENDIX B

Statement concerning a survey of the nature of graduate teaching programs in a few teaching hospitals in the eastern section of the United States

The report revolved about answers to three questions, namely:

1. The actual teaching schedule.
2. The content of the subjects taught.
3. The basic philosophy of the training program.

Agreement was reached in the following particulars:

1. The backbone of graduate training lies in intimate and sustained individual work with a limited number of patients.
2. The necessity for teaching the dynamic approach.
3. The necessity for intimate relationship between teacher and student.
4. Use of the conference and seminar method of teaching.
5. The need to select carefully candidates for graduate training.
6. The need for teachers with clinical and pedagogic skills and experiences.

There were some differences of opinion concerning:

1. The use of the didactic lecture.
2. The necessity for personal psychoanalysis of the student.
3. The nature of the initial clinical exposure, whether it should be with neurotic or psychotic patients.
4. The participation of the student in research activity.

APPENDIX C

American Board of Psychiatry and Neurology, Inc.
102-110 Second Avenue S. W.
Rochester, Minnesota

Suggested Three-Year Full-Time Training
Program for Psychiatrists

1. One year of inpatient work with an adequate variety of psychiatric conditions.
2. Six-months full-time outpatient clinic work, or its equivalent with emphasis on the study and treatment of psychoneurotic patients with a minimum of 20 interviews per week per resident.
3. Six months neurology—½ time clinical; ½ time basic.
4. Six months half-time service in the psychiatric aspects of general medical and surgical conditions.
5. Six months half-time child psychiatry and experience in working with psychologists and psychiatric social workers.
6. Six months in specialized institutional psychiatry (feebleminded, epileptic, forensic psychiatry, penology, drug and alcohol addiction, etc.)
7. During these three years it is recommended that there be available teaching ward rounds, staff conferences, seminars, journal clubs, adequate psychiatric texts and periodicals, participation in some phase of psychiatric investigation.
8. During these three years there would be adequate instruction in the basic psychiatric concepts as covered in the material recommended in the syllabus of the American Board of Psychiatry and Neurology.
9. In institutions in which there is no full-time senior staff there should be in the aggregate a minimum of
10. In planning or evaluating training, one, two, or three year programs may be worked out to include various fractions of the foregoing suggested items. For instance, a resident may devote a full day or half a day a week to the psychiatric aspects of medical and surgical conditions for a year or so while assuming major clinical responsibilities in a psychiatric hospital.

The only purpose in suggesting the foregoing program is to indicate a desirable spread of experience in the training of a psychiatrist. It is thought unwise for any teaching program to be rigidly or slavishly followed.

APPENDIX D

1. Bibliographies

The literature of psychiatry is voluminous—particularly the writings of the last few years. There is no one who has time to read all of it. Most of it is not source material. It is so great in amount that classification by any criteria and particularly according to value, is difficult. The Committee on Medical Education has been working in cooperation with the Committee on State Hospitals in gathering information on books and articles and attempting to classify it. Dr. Karl Menninger has also been working at the same general task for some time. The two Committees of G.A.P. have collected so far the titles of 546 books and 457 articles. The lists are being worked over and the results will appear from time to time. The help of many members of G.A.P. has been given in supplying references; much more will be needed in the way of giving suggestions and criticism as classification proceeds. Urgent needs at this time are: (1) list of source readings for the whole range of psychiatry, (2) a list of the better secondary references.

2. Audio-visual Aids

Undoubtedly audio-visual aids can be of value in the teaching of psychiatry. With sound films one can reproduce critical moments of human experience. With visual methods much study can be done without an instructor and much faculty time can be saved. When films are made of a patient it should be with the patient’s consent (with exceptions in the case of some patients with psychoses and some children, in which cases the consent of the legally responsible relatives should be obtained).

Elias Katz, Ph.D., Chief, Audio-Visual Aids Section, Mental Hygiene Section, Mental Hygiene Service, New York Regional Office, Veterans Administration has prepared a list of Audio-Visual Aids available for teaching psychiatry, mental hygiene, and neurology. The aids in question consist of charts, exhibits, silent and sound films, lantern slides, and recordings.

Dr. Katz states:—“Owing to inadequate clerical assistance it has been impossible to keep up with the growing amounts of material which have been coming in during the last three months. (This was November, 1946.) The list represents approximately one-third of the material which is at present available. All those who are interested are invited to communicate with the writer.”

Dr. Katz will welcome additions to his list and the Committee on Medical Education of G.A.P. will also be glad to have information on audio-visual aids to teaching.

3. Attention is also directed to the previous Reports of G.A.P.

Report No. 1—Shock Therapy
Report No. 2—The Psychiatric Social Worker in the Psychiatric Hospital

(12)