important omissions from the content of the course but suggested minor additions which mostly concerned clinical work in general practice.

After the first course the trainees commented that the videotaped interview sessions were more helpful than the audiotaped ones. They were rather unenthusiastic about role-play and some commented this form of teaching is only useful in a longer course where greater group cohesion develops. They felt that many of the case conferences were concerned with aspects of management which are relevant to psychiatrists but not general practitioners.

But the most striking criticism of the first course was the absence of trainees who were working in a general practice setting at the time. Since most of the course participants had not worked in general practice they felt it was relevant to their future needs but could only be really valuable if it emphasised more clearly the nature of work in the general practice setting where constraints of time and the type of work are quite different from a hospital SHO post in psychiatry.

For the second course we were most fortunate to have five places funded by the Medical Liaison Division of Upjohn Ltd. This meant that in the case conferences and interview skills training sessions videotapes of doctor-patient interactions in the GP's surgery were often used. The feedback from this course emphasised again the importance of trainees during their practice year. The interview skills training using videotapes were rated as excellent or very useful by 90% of the course participants and many requested a longer day and/or a longer course. The case conferences were most appreciated when there was a joint GP/psychiatrist presentation.

Conclusion

The feedback from many trainees indicated that they thought all GP trainees should attend such a course. It seems that this course covers areas of instruction which are not covered elsewhere and especially not in the experience provided by an SHO job in psychiatry. Other departments which have appropriate teachers, close links with local general practitioners and can provide videotaped interview skills training may be able to provide similar courses. But this training will not become widespread until the administrative difficulties of financing trainees in their general practice year have been overcome.

Notes on the Dynamics of Medical Student Teaching and Implications for Future Medical Practice

J. WILSON, Consultant Psychiatrist with a special interest in Psychotherapy, Henderson Hospital and Sutton Hospital, Surrey (formerly Registrar in Psychotherapy, St George's Hospital and Henderson Hospital)

I have recently addressed myself to the problems of teaching medical students. In my case it is that of teaching the principles of psychotherapy. It is difficult to teach about the doctor–patient relationship in the normally accepted lecture form. Definitions of transference, psychological defence mechanisms or empathy can be given, but this gives no impression of what is meant at an experiential level.

I would like to describe an experiential group which I conducted with medical students. This is not just to describe and explore the value of this method of teaching but to discuss the implications of the issues which were raised in the group. This is because they have important implications for the teaching of medical students and the effect this has on their future medical practice.

The group consisted of nine medical students and myself as conductor. We met on five consecutive weeks—for an hour on the first four weeks and two hours on the fifth week. The extra time on the fifth week was not intentional but arose out of an anomaly in the way the time had been allocated. A number of themes came up during the course of the group, which was free-floating with no set agenda. For the purpose of this discussion, I would like to give some impression of how the group went and also concentrate on one or two of the main issues which arose.

It would be reasonable to expect, and this indeed happened, that the students began by expressing feelings about being taught by an experiential method rather than the more normal didactic approach. This led to a discussion about how to deal with the situation. They tried ignoring the conductor, selecting one of the members of the group to act as 'the patient' and attempting to 'laugh it off'. This produced discussion at a superficial level of the nature of the therapist/client relationship. How do you deal with the 'patient role', was one question asked. Were they being treated as patients by me anyway, was another. It seemed at times confusing for them but it also opened up rich areas for discussion.

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The situation was intensified in the second group when I heard that one of the students had become a patient himself and spent the weekend in hospital, having been bitten by a snake. The anxiety level in the group became very high at this point and I felt that this needed to be explored. At the beginning of the group on the third week one of the students asked me if she could close the window. Comments were made about 'Exocet' missiles and clearly there was something felt to be very threatening which could not be talked out. I wondered if the request to close the window might be seen as a way of trying to keep some of the anxieties out. It was only in the group on the fifth week that eventually it became clear what the feared threat was. They were very frightened of the idea that I might care about them as individuals. This was because they felt very uncared for as medical students and had built up a strong denial against being cared for with considerable underlying resentment.

At this point I was able to share with them that I had felt very uncared about at the end of the previous five week group experience which I had conducted for medical students some months before. Although I had felt that the group had benefited from the experience, and in fact some members had made it clear that they had, when it came to the end the students had got up and left without any of them saying goodbye to me or thanking me. I had felt very hurt by this.

Having shared my experience of being uncared for by students, a lively discussion occurred where it became clear how easily a collusive situation occurs with medical student teaching. It is difficult to know how it starts but what happens is that the students feel that they are not wanted or cared about. This leads to, or is a response to, the teacher feeling much the same. It is easy to feel that the effort involved in teaching is not appreciated or valued. I do not understand how it occurs but this vicious circle of students feeling uncared for and teachers feeling unvalued can lead to a very bleak emotional experience for some medical students. As a role model for future practice it is appalling. It also has implications which I was able to confirm in my own experience, that of the students and of my colleagues.

If somehow, and I think quite unintentionally, this uncaring model is given to medical students, what is the result? The students feel uncared for, therefore it is difficult for them to care for their patients. Unless these feelings are explored I suggest that at a deep level students will assume that to be a doctor means to deny one's emotional needs.

However, the situation becomes worse because the model of doctors denying their needs becomes institutionalised. If, as a medical student, you did not feel cared about how can you expect to as a doctor? As in my group, these ideas seem very threatening; perhaps like an Exocet missile being fired into medical education and practice.

When I was thinking about these issues afterwards I wondered if, for instance, it wasn't relevant to the issues of waiting lists and keeping patients waiting for very long periods for appointments. As well as the practical issues involved, could it, at an unconscious level, be a way for doctors (and others) to retaliate against the patients? Patients certainly take it as a sign of neglect at times. I do not want to take away from practical difficulties with resources, etc. in the NHS, but we have also to look to other than financial solutions to some aspects of these problems.

What is the answer to these difficulties? Well, a conscious effort needs to be made to avoid the vicious circle which occurs between teacher and student and which can become such a negative and uncaring experience. Regular meetings, say once a term, between students and teachers, all together, not just representatives, may help.

But what of my group? Well, having made the breakthrough to discuss the theme of caring and being cared for, the atmosphere became much easier. Later one student talked of a friend who had recently been baptised by immersion. Perhaps, I suggested, some members of the group had felt baptised into the principles of psychotherapy. It had, at times, felt like a baptism of fire to me. However the group seemed sad and even angry that the last session was about to end. In a thoughtful and warm way we exchanged feelings about the end of the group and said our goodbyes.

Comment

In a recent paper in the *British Journal of Psychiatry*[1] the reaction of medical students to their medical education was described. The students responded to invitations to speak about their experience of training by emphasising the importance of meeting the individual needs of students and for a personal relationship to their teachers. The authors felt that some students had achieved this but a disquietingly large proportion had not. The paper also described difficulties in getting over the underlying principles of psychotherapy. This paper further confirms both the difficulties in teaching students psychotherapy and the comments on their experience of medical education. It could be suggested that difficulties will remain in teaching psychotherapy until the emotional issues involved in teaching medical students are tackled in a more global fashion. Although this might seem to be an 'insignificant loss', I suggest that attention to emotional aspects of the doctor–patient relationship underpins the whole of medical practice.

My suggestion is that the problems in teaching psychotherapy highlight an important area of potential neglect in the teaching of medical students. In spite of this, and for the reasons given, it would seem all the more important to persist. The paper by Aveline and Price illustrates a sensitive and intuitive approach to teaching psychotherapy to medical students. The authors carefully evaluated their teaching. In so far as I have had feedback on my own efforts to teach medical students, they have been much the same. I would like to suggest that a group experience as described in this paper is a useful contribution to the teaching of psychotherapy to medical students.

REFERENCE

[1] AVELINE, M. & PRICE, J. (1986) The Nottingham experiential day in psychotherapy. *British Journal of Psychiatry*, **148**, 670–675.