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*Psychiatric Teaching in Malaya**

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Like it or not, we all live on a planet teeming with variety. East and West for example have developed very differently, even though many of the problems faced by these divergent cultures are similar. True, Europe's colonising yoke in the past four hundred years introduced western infrastructure to many eastern countries, particularly in the fields of administration, communication, health, and education. However, traditional habits run deep, particularly in countries with large rural populations, and the apparent degree of westernisation can be deceptive.

I found myself having to think about these issues when I accepted a teaching post in which I was expected to help adapt a peculiarly western teaching programme to a brand new eastern medical school, in Penang, Malaya. The western teaching method emphasised students being given a much more active and responsible role in the learning process, as well as encouraging peer group discussion and constant questionning of facts and theories. In contrast, the local oriental culture emphasised the importance of obedience, not questionning your elders, passivity in the learning process, and a relative lack of emphasis on assertiveness and individualism.

Of course, importing western ideas en bloc initially produced problems, and I shall discuss these together with lessons that we in the West might learn from the experience. First, however, I will describe the teaching methods adopted in Penang, and the implications they had for the teaching of psychiatry.

What I will not do (well, only briefly!) is describe the ravishing tropical beauty of Malaya; the tropical rain forest steaming after a thunder burst; the smell of a million cloves browning in the sun; the glimpses of an infinitely older orient uniquely preserved in corners of Penang, giving visions of a China that no longer exists. This was the luscious backdrop in front of which the circumstances to be described occurred.

The medical school in Penang began taking students in the year of my arrival, 1981. From the beginning the school decided to adopt the most up-to-date methods and committed itself to two major teaching priorities. Firstly, to develop an integrated curriculum where departmental and clinical/non-clinical boundaries would be swept aside; secondly, to present the curriculum through a series of problem-solving exercises in which student initiative was encouraged. I am sure both themes are well known to McMaster, Flinders, and Newcastle (NSW) buffs, and perhaps may even be familiar day dreams to some of those working in traditional medical schools.

The demands of an integrated, problem-based curriculum meant that the teaching of all subjects, including psychiatry, had to be planned firstly so as to integrate with the teaching of other disciplines, and secondly so as to present the subject through a sequence of problems, the solutions of which required students to identify and track down relevant parts of the curriculum. This process greatly emphasised student participation. Discussion, problem solving, and identification of learning resources was done in small groups, where the teacher aimed to stimulate students to enquire in the right direction rather than to act as a fountain of knowledge. Printed on the back of every tutor's brain were the words: 'Never do for students what they can do for themselves'!

The first three years of the medical course were presented in this fashion, and during this time students would be introduced to the core psychiatric curriculum (approximately 75 hours) in addition to having about ten sessions of clinical experience with psychiatric patients. The more traditional five-week psychiatric unit attachment then took place during the fourth year.

An example of a problem given early in the second year was acute shortness of breath in a young woman. Through discussion in small groups, facilitated by a tutor, students were expected to list what they needed to know in order to fully understand the intricacies of the problem and its potential consequences and management. In this case, information from a range of potentially interacting disciplines was needed including physiology, anatomy, general medicine, and psychological medicine. Each discipline provided information in the form of learning packages, demonstrations, seminars, and occasionally lectures. Once students had worked through this learning material, they would meet for a second group session. An initial dis-

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cussion would troubleshoot for any difficulties they might have had in the learning to date, and then further information about the clinical problem would be given. This usually consisted of more information from the history or from the examination and investigations, and was either in the form of an information sheet, a set of investigation results, or occasionally photographs or video tapes. Alternatively, a further development of the problem would be introduced.

In the example given, further information revealed that the young woman had a history of eczema, had never previously had acute shortness of breath, and had just broken with her boyfriend. Further history, together with clinical and laboratory findings, was available if the information was requested. And so a new set of potential learning areas was opened up for the student. Of course, at this point the problem could have been made to develop in a quite different direction. The girl might have been pyrexial and have suddenly collapsed in casualty. (Whether a collapse or a row with a boyfriend prevailed in a problem's development often depended on which corresponding specialty could argue most convincingly for teaching time at the committee stage of problem planning!)

Usually, this process of working through the different stages of a problem took a week, and where possible relevant clinical cases were seen at the same time. In choosing problems, the best ones were often those that opened up the largest number of opportunities for teaching in related disciplines and were almost always those based on real cases; the additional specialties of immunology, bacteriology, and pharmacology all had significant inputs in addition to psychiatry.

As far as distribution of psychiatric input into the three-year sequence of problems was concerned, after a separate behavioural sciences input in year one, year two tended to emphasise the psychological aspects of physical disorders, whilst in year three the major functional psychiatric syndromes were introduced in a series of problems that were predominantly psychiatric.

The new teaching method: advantages

First and foremost, a problem-based, integrated approach teaches medicine 'as it really is'. The starting point is always a problem likely to be found in the student's future professional life. Indeed, this is one of the criteria in the selection of appropriate problems. It therefore has good face validity in motivating students to learn, and of course is a particularly attractive way to present the basic science part of the curriculum.

Psychiatry also benefits in this way, since so often it is seen and taught as a sealed off specialty rather than in the setting of general medicine, where most students will encounter it in the years ahead. This liaison teaching emphasis also influences the content of the psychiatric curriculum. More weight is for example given to the recognition and management of the less severe neurotic syndromes, the teaching of basic counselling skills, and vigilance in the detection of psychiatric disorder, including alcohol abuse. The traditional emphasis on teaching students to become mini psychiatrists was thus counter balanced. Of course, experience of the more severe psychiatric disorders and the resources available for their treatment is still important, and was gained mainly by a five-week clinical attachment to psychiatry during year four.

One final advantage of the integrated, problem-solving approach is that right from the beginning it emphasises student initiative. Although in practice, particularly early on, students are given a lot of guidance and structure in their learning, the main aim was always to keep this to a minimum at the same time giving students clear learning objectives on which they would be examined.

Thus, the student centred learning approach made it less easy for the student merely to be the passive recipient of knowledge, putting him more in the role of an active enquirer, a state of mind more suited to life after medical school.

The new teaching method: problems

Because each problem exercise involves teachers from different specialties planning and working together, the programme is potentially difficult to organise and a nightmare to run smoothly. The reliance on small group sessions is not only expensive on teacher time, but also demands different skills. Also a relentless series of weekly problems can become dull. More importantly, it may lead to a fragmented presentation of a specialty, spread out too thinly over a long time. Assume this last difficulty across the range of specialties, and at worst this may produce a rather muddled student with a very patchy knowledge at the end of the first three years.

Solutions to these difficulties were not easy in Penang. Co-ordination between teachers from different specialties required time and trust, and good communications. Psychiatry teachers are more familiar with the idea of facilitating small groups to find solutions for themselves, but other specialties found this shift from teacher centred learning to student centred learning very difficult, and required additional training in small group tutor skills. This last difficulty was worsened by the fact that the staff were almost exclusively drawn from traditional medical school backgrounds.

The biggest problem, however, was how to unfold a curriculum, in my case the psychiatric curriculum, through a series of problems in a way that was ordered, understandable, and fitted in with every other specialty. Ideally, as the student works through the problems he should slowly build up a coherent understanding of the specialty. In practice for psychiatry at least, this was best done by concentrating input on a relatively small number of selected problems, each presenting a separate theme, with the severe psychiatric disorders grouped in a series of problems towards the end of the first three years.

Of course most of these difficulties could have occurred as much in the West as in the East. One particular problem did seem peculiar to the Orient however: the attitudinal

change required of students on arrival at medical school. Most came from traditional kampong backgrounds where the extended family culture being hierarchical and valueing obedience does not encourage questioning attitudes.

To get around this problem, careful thought had to go into the provision of courses introducing the new educational methods. Despite this, however, there was a constant force from students to return to the safety of the older methods and, of course, staff too, often feeling uncomfortable in their new roles, would collude by providing teaching programmes which left little room for student initiative.

When I left Penang in 1983 this delicate balance between student and staff centred learning was still finding its natural level for local needs. However, when I returned for a brief visit a year later it seemed that some sort of stable working compromise had been achieved, albeit not the rather extreme student centred learning model initially introduced. And this compromise did seem appropriate, including as it did an emphasis on subject integration and a problem-based approach, but including a high degree of direction and supervision in the areas covered.

Lessons for traditional schools

What does this model of an integrated problem-based curriculum, together with all its attendant difficulties, offer to those of us working in more traditional schools?

Firstly, it is unrealistic and probably undesirable for traditional schools to adopt these new teaching approaches en masse. However, the methods developed in some of the more innovated and recently established medical schools do offer stimulating ideas, and with modification these can be incorporated into traditional curricula. This applies both to the integration of subject teaching, and to the use of clinical problems as the starting point in acquiring medical knowledge and skills.

Of course, the term 'integrated teaching' has recently become very fashionable, although I suspect that more is talked about integration than actually accomplished. This should be no surprise, since well established staff attitudes and habits, as well as organisational problems may all sabotage even the most enthusiastic integrated teaching programme. Certainly, one of the main lessons learnt in Penang was that careful planning between representatives of disciplines meeting together on a regular basis was an essential, albeit time-consuming, ingredient to even relatively small sections of integrated teaching.

In contrast, problem based teaching is easier to set up in traditional schools, since it depends more on the teachers' attitudes and techniques rather than the school's organisation. Again, in Penang it was found that staff needed regularly to review the teaching strategies they were using, from time to time attending workshops aimed at developing skills in small group teaching techniques, for example. This focus on teaching methods slowly resulted in the traditional ideas of the teacher as pure information giver being revised, and an increasing use of more student centred teaching techniques. The main lesson here seemed to be the importance of giving teachers, whatever their specialty, the necessary training, support, and supervision in the teaching methods used.

As for the student, I think western values may prepare him a little better for student centred learning than do eastern values, although I admit that current 'A' level science curricula in Britain remain excessively teacher centred, and are a poor preparation for future student centred learning at university. However, all students, be they from the West or the East, given adequate preparation and careful explanations of the learning methods in use, seem to adapt quickly in my experience, often more quickly and more flexibly than their teachers!

There are of course all sorts of forces which resist integrated teaching programmes, or resist the use of methods other than didactic teaching, and this is particularly true of the first two years of traditional medical courses. Psychiatry is no exception to this, taught as it often is as a subculture sealed off from the rest of medicine. Of course, this is at odds with clinical reality and it is interesting to reflect that Penang, after carefully weighing up the options when planning its new medical school, eventually decided that the traditional way of training doctors left a lot to be desired, and like many other schools initiated in the past two decades, opted for a rather different approach.

Dr Rose was Associate Professor of Psychiatry at University Sains Malaysia, Penang, Malaya, 1981–1983, and recently made a return visit sponsored by the British Council.

European College of Neuropsychopharmacology (ECNP)

The European College of Neuropsychopharmacology (ECNP) will hold its constituent meeting in Brussels on 7 and 8 May 1987.

The goals of the ECNP are to stimulate high quality experimental and clinical research in neuropsychopharmacology with a special emphasis on co-ordinating and promoting the scientific activities and standards between countries in Europe.

The topics of the meeting will include basic and clinical aspects of the pharmacological treatment of psychoses, affective illnesses, and sleep disorders. Applicants interested in participation should send their curriculum vitae (for consideration of future membership of the ECNP) and proposed titles of any scientific communication they may wish to present to: Dr P. Bech, Department of Psychiatry, Frederiksborg General Hospital, DK-3400 Hillerød, Denmark. (Deadline for applications: 1 April 1986).