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Building Bridges: the Relationship of Medical Education to Health Promotion

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ABSTRACT

FACULTY OF EDUCATIONAL STUDIES

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This research interviewed, and examined curriculum documentation produced by, all those who coordinated the courses and attachments that make up an undergraduate medical curriculum to examine where the goals, content and processes of medical education overlap with those of health promotion, and where they diverge.

The main areas of overlap were the interest shown by most of the specialities in: patient centredness, especially communication skills, which were essentially self empowerment; holism which looked at the patient in their social and psychological entirety; and prevention, including the giving of lifestyle advice. Some specialties were also interested in: 'relative health', i.e. helping patients to feel as 'well' as possible; behaviour change and psychological approaches; epidemiology and risk; and critical appraisal and evidence base. There was some recognition of the importance of teaching students about their own health, and concern about levels of student stress. Staff also intended to reduce the amount of factual information, engage students in active and self directed learning, identify and teach core knowledge, skills and attitudes, and deliver the curriculum in a student centred manner.

The main divergencies were: a lack of interest in positive health; a strong tendency to identify health promotion simply with prevention; the marginalisation of a psycho-social perspective, and in particular a lack of interest in broader social perspectives; and a dismissal of the reflective and interpretive epistemologies of the psycho-social sciences as 'commonsense'. The parts of the curriculum that were most likely to support the concepts and principles of health promotion tended to be seen as of lower status than those that concentrated on 'high tech', interventionist medicine. In practice, the approach to teaching and learning employed was mostly a traditional one, with a strong emphasis on the lecture method, the teaching of facts, and on formal assessment, especially in the first two years.

This research suggests that those who would develop health promotion in medical education should build positive links with the areas of overlap rather than starting from a negative and confrontational perspective, and use language and concepts familiar to medicine, while emphasising the relevance of their discipline to medical contexts. They should attempt to integrate health promotion across the curriculum, especially in the clinical specialities, and concentrate particularly on developing health promotion in the parts of the curriculum likely to provide a supportive environment for it.

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LIST OF ABBREVIATIONS USED

In the text

BMA: British Medical Association
DoH: Department of Health
HEA: Health Education Authority
GMC: General Medical Council

In the tables

Basic Sci: Basic Sciences
CFC: Clinical Foundation Course
Elms: Elements
EPC: Early Patient Contact
ENT: Ear, Nose and Throat
Gastro:Gastronintestinal
GU: Genito Urinary
HE: Health Education
HP: Health Promotion
Lympho:Lymphoreticular
Pall: Palliative Medicine
PHM: Public Health Medicine
PMC: Primary Medical Care
O&G/ Obs. and Gynae: Obstetrics and Gynaecology
SBOM: Scientific Basis of Medicine

CHAPTER ONE

RATIONALE

THE CENTRAL CONCERNS OF THE THESIS

Aims

One aim of this thesis is a theoretical one, and attempts to contribute to an understanding of the relationship between health promotion and medical education:

- ***The main aim of this thesis is to explore the relationship of the 'two worlds' of health promotion and medical education. It will attempt to look at where the goals, content and processes of medical education overlap with those of health promotion, and where they diverge, in order to discover whether it is possible to bring them together into a more effective relationship.***

In addition, the thesis aims to be of some practical use to those who wish to develop health promotion in medical education:

- ***A secondary aim of this thesis is to suggest some strategies and priorities for action in developing health promotion in medical education.***

The research

Full details of the research methodology used will be given in the next chapter, but it may help to explain this rationale chapter to provide a few brief details at the outset. The context for this investigation is a study of Southampton Medical School. The source of data for the study is a series of interviews with those who coordinated all the 31 courses which made up the undergraduate medical curriculum, other individuals in key positions within the Medical School, all the staff who taught Public Health Medicine and Primary Medical Care, and several staff involved in the teaching of the psycho-social sciences. The research will also analyse the 'medical curriculum booklet' which described in some detail the various courses which made up the curriculum. The study will attempt to discover what staff thought was taught about the various key issues that relate to health promotion, and their attitudes towards these issues. So, where the objectives talk of 'the medical curriculum,' this means the medical curriculum as seen through staff eyes.

Goals of this chapter

This chapter will outline some key theories of health promotion, to help provide the framework for the empirical investigation which follows. It will attempt to clarify what

health promotion is about, examine the key debates within it, and indicate where, judging from published evidence, medicine and medical education appear to be located within those debates.

As various issues are identified as of central significance for health promotion in medical education, specific objectives for the research will be formulated: they will be indicated in the text by ***indented, bold italics.***

Calls for medicine and medical education to do more to promote health

One major impetus for this thesis is the frequent calls that are being made from within medicine for medical education to do more to promote health.

The *'Edinburgh Declaration'* of the World Federation for Medical Education (1988), stressed the need for medical studies *'to put increased emphasis on promotion of health and the prevention of disease'.* It suggested that:

> *The aim of medical education is to produce doctors who will promote the health of all people, and that aim is not being realized in many places, despite the enormous progress that has been made during this century in the biomedical sciences.*

In the same year, the first working group of the Ministerial Consultation for Medical Education in Europe (1988) in the *'Lisbon Initiative'*, came to the view that:

> *Particular attention should be paid to complementing the traditional teaching of disease management with the acquisition of knowledge, skills and attributes related to continuity of care, health promotion and disease prevention.*

In a keynote article in 'Medical Education' in 1992, Sullivan called for doctors to *'participate in the formulation of plans to implement greater health promotion and disease prevention efforts'.*

For some time the General Medical Council (GMC) has been calling for medical education to be more involved in *'the promotion of good health'* (GMC, 1980, 1987a, 1987b). In its recent, highly influential document, *'Tomorrow's Doctors'*, health promotion is indeed the very first goal it sets for medical education:

> *The student should acquire a knowledge and understanding of health and its promotion, and of disease, its prevention and management, in the context of the whole individual and his or her place in the family and in society.*
> (GMC, 1993, p.12)

The document also includes an emphasis on health promotion in its final recommendations,

and includes some heath promoting competences in its concluding list of '*attributes of an independent practitioner*' (*ibid,* p. 26). However, outside of these general statements, it has nothing specific to say about health promotion: health promotion is simply set alongside '*disease prevention*' as a pair of terms which are never further defined, a confounding of the two terms which is almost universal in medicine and medical education (Wallace *et al*, 1990; Sullivan, 1992; Meakin and Lloyd, 1996). This dearth of detail about health promotion is in contrast to the richness of the document's discussion of many other areas of the curriculum, most obviously the treatment of disease and illness. It routinely places the word *'health'* in partnership with *'disease'* and or '*illness*', for example in suggesting that learning should include '*knowledge and understanding of the general structure and function of the human body and workings of the mind in health and disease*' (GMC, 1993. p. 25). So, although paying lip service to health and health promotion, the detailed concerns of the document are in fact all about disease.

It would appear then that those at the forefront of medical education have got as far as seeing health promotion as a worthwhile aim, but without having much detailed idea of what the term might means in a medical context.

- ***This thesis will attempt to suggest what health promotion might mean in medical education, using concepts and terms relevant to a medical context.***

Health Promotion's view of medicine

Those at the forefront of medicine may be becoming keen on health promotion, but most of those in health promotion exhibit a highly negative and suspicious attitude towards medicine. Health promotion is often seen by the specialists who practice and write about it as medicine's opposite. As Bunton and Macdonald (1992) say, '*much health promotion literature has developed in reaction to a traditional medical perspective on health*'.

In 1986, as part of its general drive to define and clarify the scope and nature of health promotion, the World Health Organisation (WHO 1986b) called on the health professions, including medicine, to *'reorient'* to health promotion. The notion of *'reorientation'* suggests that the WHO feel that a concern with health promotion involves re-examination of what medicine is centrally about. Many within health promotion doubt that medicine is actually willing to make the fundamental changes they would think necessary to promote health. The attitude of the WHO itself towards doctors tends to be sceptical:

> *Because of the traditional orientation of the medical profession towards disease prevention, its contribution to health promotion is likely to be limited.*
> WHO (1982a)

Those involved in health promotion often suggest that the approaches and models used in

medicine are too limited, too negative, too disease oriented, and too doctor centred to be of any use in health promotion (McKee, 1988; Harlem, 1990; Green and Kreuter, 1991; Cribb and Dines, 1993). For example, Bunton and Macdonald (1992) suggest:

> *the place of medicine within health promotion has been problematic. The 'bio-medical model' has been found restrictive for the purposes of health promotion.*

It is the intention of this thesis to examine the empirical basis of such criticisms, and attempt to discover the extent to which the negative view of medicine and medical education that tends to be held by most in health promotion is justified.

The changing nature of medical education

Health promotion in medicine is hardly a new idea: it is more the case that it is 'rediscovered' periodically. Hippocrates (quoted in Fowler, 1988) pointed out its importance for doctors:

> *These things we ought to consider most attentively: the mode in which the inhabitants live, and what are their pursuits, whether they are fond of eating and drinking to excess, and given to indolence, or fond of exercise and labour, and not given to excess in eating and drinking.*

More recently, but still nearly a century ago, Flexner (1910) 'rediscovered' it:

> *The physician's role is fast becoming social and preventive rather than individual or curative. Upon him society relies to ascertain and through measures essentially educational to enforce the conditions that prevent and make positively for mental and moral well-being.*

In current attempts to 'rediscover' health promotion in medicine, it may be as well to note that medical education appears not to be as completely uniform or as hidebound by tradition as some of its critics suggest. It may be that those who criticise medicine and medical education for using restrictive models are not sufficiently aware of some of the debates that have taken, and are taking, place in medicine, debates which may give some cause for at least cautious optimism about the fertility of medicine and medical education as a ground for health promotion. Perhaps even more than with any other profession, there have been long running controversies about what medicine and medical education are and should be about, many of which overlap with debates within health promotion. There are, for example, discussions about the right approach to take to prevention (Fowler, 1988; Herbert, 1989), the need for a patient centred, holistic approach (Tuckett *et al*, 1985; McWhinney, 1989) and the need for teamwork in health care (Werner, 1978; DoH, 1993).

It is reasonable to assume that such debates have made an impact on the Medical School

that is to be subjected to scrutiny here, and that many staff will at least be aware of, and even possibly active in, such debates. So this thesis will not employ a 'deficit model' of the medical staff interviewed, but will attempt to examine their intentions, aspirations, concerns, principles and values, and the resultant curriculum aims and processes, to discover the extent to which their concerns overlap with the concerns of health promotion.

- ***This thesis will attempt to discover what medical staff were trying to achieve in their teaching, as the starting point for uncovering the links and overlaps in the relationship between the medical curriculum and health promotion.***

HEALTH

Rationale for looking at health

There has been much discussion about the correct approach to use in health promotion, but those who have written most convincingly about it have seen as an essential foundation an examination of the nature of health (Downie, Fyfe and Tannahill, 1990; Cribb and Dines, 1993; Tones and Tilford, 1994). The Health Education Authority (HEA) has recently commissioned and published a 'core curriculum' on health promotion for medical students (Pringle, Fragstein and Craig, 1997) in which it suggests that a study of concepts of health is an appropriate starting point for teaching medical students about health promotion. So it is to the issue of health that we too turn first.

Health as the absence of illness and disease

To many people, to be healthy is simply not to be ill: they would endorse a basic and common sense view of health as the absence of disease (Blaxter, 1983; Williams, 1983; Calnan, 1987). The two states are seen as obviously clear and distinct: if a person is not 'ill' then they are 'well'.

Many in health promotion associate this model of health predominantly with doctors (Catford and Nutbeam, 1984; Green and Kreuter, 1991). It is thus often called, some would say unfairly (Redfern, 1994), some version of 'the medical model'. It is often claimed that medicine has no real concept of health (Seedhouse, 1986). As far as medicine is concerned, health is the state the patient is in when outside of the doctor's orbit, it is unproblematic, an afterthought, and from the doctor's point of view, not interesting (Gordon, 1988). Only disease and illness bring the doctor to the patient, and only they are the proper, and fascinating, concern of medicine (Fowler, 1986).

The disease centred approach has been called the 'pathogenic' model of health, to distinguish it from the 'salutogenic', or wellness, model (Antonovsky, 1979, 1987). It is not usually seen as being a useful basis for the positive promotion of good health, as it cannot

encompass such a dimension, although it is certainly possible for this model to co-exist with a model of 'disease prevention'.

The pathogenic model of health is often dismissed or minimised by those constructing taxonomies of health promotion (Catford and Nutbeam, 1984), but, as Dubos (1979) has pointed out, for many people in many contexts it may be highly appropriate. For some, such as the poor, the dispossessed, the diseased and the starving, the more positive models of health which we shall shortly examine may well be what Dubos terms a '*mirage*', unattainable in practice given the difficult conditions under which they live (Blaxter, 1990; Calnan and Williams, 1991). Aiming for an absence, or even simply a reduction in the level of, disease, may be all that is realistic and ethical in the circumstances. The pathogenic model is then an important model to retain as one of the cornerstones of health promotion activity, and those in the fortunate circumstance of being able to have more positive aims should not minimise its significance for the disadvantaged.

Positive health

Famously, the WHO defined health as *'a complete state of physical, mental and social well-being, and not merely the absence of disease or infirmity'* (WHO, 1946). This definition has been much criticised, most usually for presenting an impossible and unhelpful goal (Downie *et al,* 1990; Cribb and Dines, 1993). However, at the time, this definition had the virtue of paving the way for a more 'salutogenic' approach, in which health is viewed as a positive state in its own right. The salutogenic approach has been most famously summarised by the Ottawa Charter (WHO, 1986b) which stated that health is '*a positive concept, emphasising social and personal resources, as well as physical capabilities.'*

As well as being foreign to most doctors, the salutogenic model of health is more difficult than the pathogenic for most ordinary people to relate to, as most people find it more difficult to talk about health than to talk about illness (Blaxter and Patterson, 1982; Calnan and Williams, 1991). Nevertheless, salutogenic models now form the cornerstone of many of the most highly regarded typologies of health promotion (Downie, Fyfe and Tannahill, 1990; Cribb and Dines, 1993; Tones and Tilford, 1994) so this thesis will take them as seriously as the pathogenic ones, in its attempt to bridge the 'two worlds'.

Health as a continuum or a spectrum

So far in this chapter, health and illness have been discussed as if they were alternative states, incompatible with one another. Many in health promotion have argued however, that this simple dichotomy between health and illness is a false one. Health and illness are not absolutes, but can be seen as existing on a continuum in which a variety of 'levels' are possible. Drawing on the language of prevention (Tones, 1981), and starting at the negative end, we have the 'tertiary' level of the patient with established and incurable disease.

Moving along to the 'secondary' level, we have the temporarily ill patient who can hope to return to function, and may wish to know how to avoid becoming ill again. At the 'primary' level we have those who are 'well' and wish stay that way. At this 'primary' level an almost infinite range of states is possible, from the 'just functioning' level of the couch potato, through to the supreme physical fitness of the Olympic athlete.

More recently it has been suggested that to think of health and illness in a linear way is also not helpful. A view has emerged of them as distinct but overlapping concepts (Downie, 1990). Perhaps most usefully of all, some such as Aggleton (1990) and Cribb and Dines (1993) have suggested that health and illness should be conceived of as spectrum, with various degrees of health and illness co-existing across a range of dimensions, which include, for example, mental, emotional, physical, social and ecological dimensions.

If health is a spectrum, it then becomes possible to have complex maps of health and illness, which allow for a person, group or community to be healthy in some respects and not others. So, for example an obsessed fitness fanatic who sacrifices their family and ignores their personal problems in the quest for performance could be seen as physically fit but emotionally and socially unhealthy, while a person who is dying of cancer but has made peace with themselves, their friends and their maker may be seen as physically very unwell, but emotionally, socially and spiritually healthy.

Health as a resource

For some people, and in some societies, health can become a goal in its own right which supersedes all others. However, many in health promotion see such an attitude, often summarised by the term 'healthism' (Crawford, 1980) as dangerous. For many in health promotion there should always be higher goals than health (Chapman, 1983). At the personal level, human relationships, harmony, happiness, and personal achievement are seen by some as more important (Seedhouse, 1986). At the social level, issues such as the rights and dignity of the person, political freedom, democracy, and justice are often thought to take precedence (Doyal, 1983). For many, the pursuit of health takes place within an ethical, political and humanitarian framework and strong limits (Doxiadis, 1990).

Within such a framework of concern to avoid 'healthism', the concept of 'health as a resource' has been found to be productive. The Ottawa Charter (WHO, 1986b) suggested that we should see *'health as a resource for every day life, not the objective of living'.* Health promotion then becomes *'the process of enabling people to increase control over, and to improve, their health',* at whatever level they are at, and as far as they need, to realise their own goals. These key concepts, of health as a 'resource' and health promotion as 'enabling an increase of control' have been found to be useful in a wide variety of contexts (HEA, 1989).

The concept of 'health as a resource' appears to fit with the concepts of health of many ordinary people. Many lay people when questioned about their understanding of health, talk of the importance of being 'well enough' to do what they want, to function efficiently and effectively, to be able to perform and to feel sufficiently well to enable them to get on with their lives; they see health is a backdrop for activity, not an end in itself (Williams, 1983; Calnan, 1987; Lupton, 1994).

- ***This thesis will examine the extent and nature of teaching about health, as opposed to illness and disease, in the medical curriculum, and staff attitudes towards the idea of health.***

Health is physical, mental and social

We have already indicated, when we looked at the idea of 'health as a spectrum' that many of those involved in health promotion see health as multi-dimensional, depending on a complex inter-relationship between the parts and the whole. Back in 1946 the WHO defined health as a state of *'physical, mental and social well-being'* (WHO, 1946). Some have said that this definition still represents only a partial view, and that there are further dimensions to health such as spiritual (Wilson, 1974) and environmental, sexual and sensual (Aggleton, 1990).

But although many would recognise that health is multi-dimensional, the various dimensions have by no means received equal treatment in the health service or in health promotion. Mental health has often been described as the 'Cinderella' of the health service, under-resourced and undervalued (DoH, 1975). Psychiatry has tended to be dominated by the traditional western, pathogenic, view of health and illness, characterised by a search for the physical causes of mental disorders, and on pharmacological solutions (Clare, 1985). Salutogenic approaches are rare in Psychiatry: medical approaches to mental health are almost invariably negative, and 'mental illness' would be a more apt title in most cases (Kennedy, 1988). Mental health has in practice been neglected by health promotion too, with most of the energy and resources being channelled into the activities designed to promote physical health and reduce the risk of physical disease (Atkinson, 1990).

This neglect of mental health by both medicine and health promotion is odd, as in the everyday world the pursuit of mental health is of paramount importance to most people. The average person appears to value happiness and social relationships more than they do physical health (Helman, 1990), while the attraction of physical health practices, such as taking exercise or eating a healthy diet is for many people the feeling of immediate wellbeing they produce rather than long term health gain (Barr, 1985). Activities such as assertiveness and stress reduction training are increasingly of interest to ordinary people, including those under pressure in the health service (Burnard, 1991) who would in no sense

see themselves as 'mentally ill', but are keen to feel happier, more in control and more in harmony with themselves and their fellows in their everyday lives.

Social health may be difficult to delimit, and 'the healthy society' sounds to many more like a nightmare than Utopia, but most would recognise that health has social dimensions. For example, most would recognise that health is moulded by larger forces than merely individual health behaviour, and that the social and physical environment in which a person lives, the resources over which they have command, and the opportunities open to them, play a major part in shaping their health (Graham, 1984, 1993; Armstrong, 1987). Sociologists have pointed out the extent to which health and illness are social constructs, and depend on social definitions of what is normal and acceptable: different groups and cultures define health in different ways, and what constitutes a problem to one may not be noticed by another (Richman, 1987; Lupton, 1994). Such cultural clashes often confuse communication between doctors and patients who may be working within quite different belief systems (Bochner, 1983; Tuckett *et al,* 1985; Helman, 1990). Individuals are partly defined by their social roles and social relationships, and managing these effectively is for most people an important dimension to any feeling of well being (Blaxter and Patterson, 1982). Ethically too, health can be seen as having a social dimension, and many doubt that a society can be seen as healthy if it is not equitable, if groups within it experience major disparities and lack the basic determinants of health, such as decent food and a clean environment in which to live. This concern with equity is seen by many, including the WHO, as a fundamental principle of health promotion (WHO, 1986b).

Health is then often seen by those involved in health promotion not as a discrete and absolute state, but depending on a holistic balance between mind and body, and between the person and their environment (Wilson, 1976; Aggleton, 1990; Berliner and Salmon, 1980). Some, such as Seedhouse (1986) and the WHO (1986a), have attempted to evolve complex models of health, which do justice to its diversity and interrelatedness.

Psycho-social approaches in medicine

It has been often suggested that the western medical model of health has traditionally focused almost entirely on physical health, and taken a highly mechanistic and reductionist view of health and the human body (Berliner and Salmon, 1980; McKee, 1988; Lupton, 1994). However many who have written from within medicine are clearly aware that health is by no means just a physical or a biological matter, but mediated by mental and social forces (GMC, 1980, 1987a, 1987b, 1993; White, 1988; McWhinney, 1989.) Some claim that medicine is starting to place the person rather than the disease as the centre of medical activity (White, 1988).

Medicine is said to be starting to take seriously the importance of the social and cultural

context in which people live as a guide to both the diagnosis of the problem and an indication of the way to solve it (Sankar, 1986). The total quality of a person's life, the acceptability to them of what is being offered, and ultimately the ability of the rest of society to pay for it, are increasingly seen as having to be taken into account when making an assessment of a problem and planning an intervention (Fallowfield, 1990). Doctors are being urged to develop the skills needed to understand and work with the person as a whole, their emotions, their understandings, their health practices, their social and cultural networks, and even their spiritual beliefs (Armstrong, 1986; Berliner and Salmon, 1980; McKee, 1988).

Many of the key policy documents on medical education, including *'Tomorrow's Doctors'* have emphasised that it is important for medical education to take a psycho-social approach, to teach students to recognise the interdependence of the different dimensions of health and the 'body- mind-society' link (GMC, 1993).

- ***This thesis will examine the extent and nature of teaching about psycho-social aspects of health, illness and disease in the medical curriculum, and staff attitudes towards this issue.***

HEALTH PROMOTION IN MEDICAL EDUCATION

The teaching of health promotion in medical education

Surveys of medical education in the early 1970s in Europe concluded that *'little emphasis was placed on health promotion'* (Metnecki and Voros, 1972). In the 1980s, surveys in the US showed that health promotion in medical education appeared to be quite well developed there (Bartlett, 1984; Jonas 1988). Partly inspired by this work in the US, in the late 1980s and early 1990s several conferences attempted to discover what was happening to the teaching of health promotion in medical schools in Britain and Europe. The resultant publications, and other writings at the time, took a cautiously positive view. They suggested that health promotion was beginning to make a scattered appearance in several medical schools, and there were a variety of small scale initiatives in teaching and learning about health promotion taking place in medical schools in Britain (Weare 1986, 1988a and 1988b; Gillies and Elwood 1989; Randall, 1989; Crimlisk 1990; Whitehead, 1990; Amos *et al* 1991; Sharp, 1990) and in Europe (Weare and Kelly, 1990; Weare, 1990a). They concluded that such work had usually been initiated by innovative individuals and small groups, who were often prepared to work without support from the medical school establishment.

Several calls were made for medical education in the UK to be more involved in health promotion (Weare 1988c; Weare and Kelly, 1990; Amos, 1991; Redfern, 1994), but it appears that the UK continued to lag behind the US at this time (Wolf *et al*, 1990a; Wallace *et al*, 1990; Taylor and Moore, 1994). A survey by Sharp (1990) suggested health promotion was still not to be found to any great extent in most medical schools in the UK. It is hard to tell whether matters have improved since that time, as there have been no further surveys across medical schools. The only recent study, in 1996, by Meakin and Lloyd (1996) surveyed staff and students at the Royal Free Hospital School of Medicine. It found that 60% of clinical and 44% of preclinical teachers said they aimed to teach about disease prevention and health promotion, although only 50% of students said they had been taught about it in any detail. This study found that students were more likely than teachers to see learning about health promotion as equally important as learning about diagnosis and treatment, while both staff and students thought health promotion should be integrated into all years and all clinical courses.

Most of the research into health promotion in medical education cited above made use of questionnaire surveys. As such it could be argued that the instruments employed may have been too crude for such a wide ranging, complex and potentially ambiguous subject area. The questions asked may well have failed to tap into what this thesis will argue are the wide range of issues that relate to health promotion, many of which would not be seen by respondents, and possibly not even by those who undertook the research, as included in health promotion. Furthermore, some work has shown that doctors and health promoters may attach rather different meanings to essential terms such as *'health promotion'* and *'health education'* (Collins, 1984; Boulton and Williams, 1986; Weare, 1986, 1988a; Redfern, 1994), and such semantic confusion is often a pitfall in survey type approaches. The shortcomings of previous work, and a justification for the need to take a rather different approach, will be explored more deeply in the methodology chapter.

As we have already briefly mentioned, a recent report by the HEA (Pringle, Fragstein and Craig, 1997) has attempted to identify what it terms *'core knowledge and skills relating to health promotion'* in medical education, echoing an earlier, similar attempt in the US (Wallace *et al*, 1990) and 'map' them through the curriculum of Nottingham medical school. This builds on earlier work at the school, described in Gillies and Elwood (1989). The HEA is currently engaged in a project, examining the teaching of health promotion in three medical schools in England and attempting to promote its 'quality' (Cowburn, 1997).

So, although detailed knowledge about the extent and nature of teaching about health promotion in medical education is scarce, and the survey type research on which it is based perhaps too crude an instrument to always measure what matters, it would appear that health promotion has at least some presence, and meaning, in UK medical schools. It may then be

possible to ask staff about it directly, and seek it, under its own name, in the medical curriculum in question.

- ***This thesis will look at where 'health promotion' and/or 'health education' were taught under those names in the medical curriculum, what was included under those titles, what staff understood by the terms, and what attitudes they had towards them.***

Health promotion under different names

Given that health promotion is such an eclectic discipline (Bunton and Macdonald, 1992) it would seem unrealistic to expect it to necessarily retain its own name in all circumstances. There may well prove to be a difference between the concepts of health promotion held by those who practice it as specialists, and those who teach medicine. Those discussing the place of health promotion in medical education have already found it impractical to restrict their scope to where 'health promotion' is being taught under that precise name, and have included a wide variety of overlapping and related disciplines and issues in their area of concern (Bartlett, 1984; Weare, 1988c; Gillies and Elwood 1989; Whitehead, 1990).

So, in looking for health promotion in the medical curriculum in question, and in attempting to elicit staff attitudes and perceptions about it, it may well be necessary to seek it in a range of places, guises and under a wide variety of names.

- ***This thesis will not restrict its vision to where health promotion and/or health education were taught in the Medical School under those exact titles, but will attempt to discover evidence for the concepts and principles of health promotion, wherever they were found and whatever they were called.***

The issue of the integration of health promotion into courses will be returned to later in the chapter, when we look at integrated approaches to health promotion.

MODELS OF HEALTH PROMOTION

SOME BASIC QUESTIONS

Health education or health promotion?

Before we look in detail at models, we need first to clarify a basic problem of nomenclature, which is whether to use the term 'health promotion' or 'health education', and the meanings of these terms.

In the 1980s, some writers criticised health education for being, as they saw it, a series of individually focused campaigns designed to change lifestyles, and which thus 'blamed the victim' for their own ill-health (Seymour, 1984; Rodmell and Watt, 1986). As a result there was for some time an emphasis on health promotion, which was seen as advocating structural changes to the social, political and public health fabric of society. This lead to the marginalisation of health education, and indeed of all educational activity in favour of socially focused approaches, for some years.

Some fought back on behalf of health education (Williams, 1984; Tones, 1987b) and today this debate has largely lost its fire. Health education and health promotion tend now to be seen as 'overlapping spheres' (Green and Kreuter, 1991) and the differences between them as about levels of intervention rather than ideology or values. It is seen as appropriate to include psychological approaches, aimed at individuals, in the full repertoire of health promotion interventions. It has been recognised for some time that there can be models of health education which complement the full range of those in health promotion, including social change and radical models (Minkler and Cox, 1980; Draper *et al*, 1980). Health education is seen as concerned with attempts to change knowledge, attitudes and behaviour through learning in its broadest sense (Tones and Tilford, 1994), and is included within the wider remit of health promotion which also takes in measures which attempt to bring about change in the social and physical environment, through for example legislation, economic and fiscal measures, and organisational change (Catford and Nutbeam, 1984). So most now agree that both health education and health promotion are necessary. Indeed Green and Kreuter (1991) suggest that they complement one another, and that health education prevents health promotion from becoming coercive, while health promotion prevents health education from being naive.

Tones and Tilford (1994) suggest a helpful way forward which puts the two into a clear, symbiotic and synergistic relationship:

> *Health promotion consists of any combination of education and related legal, fiscal, economic, environmental and organisational interventions designed to facilitate the achievement of health and the prevention of disease.*

They summarise it in the, much quoted, formula: *'Health Promotion = Health Education x Healthy Public Policy'.*

This thesis take its tone from such pragmatic approaches, and will, in general, include health education within health promotion.

The HEA's core curriculum for health promotion, suggests that medical students should '*understand the distinction between health education and health promotion'* (Pringle,

Fragstein and Craig, 1997). It will be interesting to see whether the medical staff to be interviewed have at present any awareness of this issue.

- ***This thesis will investigate whether staff distinguished between the terms 'health education' and 'health promotion' and if so, what was the nature of the distinction they made.***

Models and typologies

We turn now to look at health promotion in its own right and in its own terms.

The theory of health promotion was for some time characterised by a debate about which model to use (Draper *et al,* 1980; French and Adams, 1986). As we shall see, the debate has now moved on to some extent, to develop more eclectic and synthetic 'metamodels', which take the best of simpler models, and apply them according to the circumstances (WHO, 1986b; Green and Kreuter, 199; Tones and Tilford, 1994) . However most of the issues of principle that were discussed in the models debate still apply. It is also the case that some of the more basic models may be more relevant in a medical context, and be more familiar, and make more sense, to medical staff. So we will first examine some of the most widely used and discussed models in health promotion.

To try to make sense of the models debate, a wide range of typologies of models of health promotion grew up (Rawson, 1992). This thesis will not employ any one typology, but will attempt a, necessarily simplistic, synthesis of those most often used (French, 1990; Cribb and Dines, 1993; Downie, Fyfe and Tannahill, 1990; Ewles and Simnet, 1995; Naidoo and Wills, 1994; Tones and Tilford, 1994).

PREVENTION

The inclusion of prevention within health promotion

We turn now to examine some of the most commonly used models of health promotion, starting with the one that is the most commonly associated with medicine, prevention.

Some specialist definitions, such as those of Nutbeam (1986) do not include disease prevention as part of health promotion, seeing it as too individualistic and negative. However, most taxonomies would include it (Draper *et al*, 1980; French, 1990; Naidoo and Wills, 1994; Ewles and Simnet, 1995), as most would say that health promotion, as it is usually defined, stems from a belief that illness can be, at least partly, prevented. So this thesis will include it in its area of interest.

The failure of the bio-medical approach, and calls for prevention

The need for prevention is most usually cited in the case of the two major causes of premature death in the developed world today, cancer and cardio-vascular disease (Jacobson *et al*, 1991; DoH, 1992). Such diseases appear not to be amenable to bio-medical intervention alone: despite vast sums spent on attempts to cure them through surgery, drugs and in the case of some cancers, radio-therapy, prevention is often claimed to be the only way to reduce mortality significantly (WHO, 1982b, 1984a, 1988a; Commission of the European Communities, 1990a). The new scourge of HIV/AIDS has so far posed the same challenge (Corless and Pittman-Lindeman (eds) 1990). Where infectious disease continues to be a major cause of death in the developing countries, prevention is still seen as the main means of control (Klouda, 1983).

Prevention can take many forms. The so called 'medical' approach to prevention is usually taken to mean population based approaches, based on an assessment of 'risk' of a specified disease, followed up with physical interventions, such as screening or immunisation, and/or 'lifestyle advice' (McPherson, 1985; Fullard, 1992; Mant, 1992; Family Heart Study Group, 1994.) Criticism of this approach is probably the arrow aimed most often at medicine's heart by health promoters, who find it variously simplistic, negative, top down, doctor centred, and didactic (Nutbeam, 1986; Bunton and Macdonald, 1992; Cribb and Dines, 1993; Naidoo and Wills, 1994). Those involved in health promotion have pointed out that the significance of medical preventive interventions tends to be overestimated in terms of public esteem and resource allocation. Although it is popularly believed that infectious diseases have been conquered by medical interventions, including preventive interventions such as immunisation, in practice the dramatic decline in infectious disease in the western world in the late nineteenth and early twentieth centuries was due mainly to public health measures, such as improvements in sanitation and nutrition (McKeown, 1979; Bastian, 1989).

However, although we may feel that their significance has been overestimated, 'medical preventive' activities are in themselves unexceptional, and indeed can be of some value. Although all the most popular typologies of health promotion categorise prevention as a model in its own right (French and Adams, 1986; French, 1990; Cribb and Dines, 1993; Downie, Fyfe and Tannahill, 1990; Ewles and Simnet, 1995; Naidoo and Wills, 1994; Tones and Tilford, 1994) it is in fact merely a starting point, an aim, not an activity. It does not imply any particular method, strategy or focus, but instead demands a further range of theories, for example about the best way to change behaviour, about the causes of health and disease, and whether these causes are individual or social. At present preventive interventions tend to be medically driven, and the medical profession are the ones who are currently most keen to promote them (Jacobson *et al*, 1991, DoH, 1992). But there is no *a priori* reason why prevention is necessarily authoritarian, although of course it may be if

doctors attempt to impose an agenda of change on unwilling patients (Stott and Pill, 1990). Nor is there any intrinsic reason why preventive activities cannot be patient centred. To take breast screening as an example, at the individual level a GP could be responding to a patient's request for a scan, at the community level 'well women' clinics might provide screening as a result of pressure from a group of concerned patients, while at a national level, the age range of patients scanned might be extended as the result of public pressure.

Prevention in medicine

If one of the key principles of health promotion is to 'start where people are' (Weare, 1992) then we need to take seriously the fact that the prevention of disease is by far the most common and widely held goal for health promotion among ordinary people (Calnan, 1987; Williams, 1987). Furthermore, in so far as health professionals have a model of health promotion, the prevention of illness is still likely to be the aim to which they relate most easily (Simons-Morton and Simons-Morton, 1987). Where doctors are concerned with health promotion at all, the prevention of ill health tends to be the aim that they find most comfortable and appropriate (Collins, 1984; Redfern, 1994), and most health promotion by doctors has prevention as its goal (Orleans *et al*, 1985; Nussel, 1990). It is certainly what most of the money that is poured into the area by governments and other agencies is intended to do (Department of Health, 1992).

In so far as health promotion is thought by doctors to be taught in medical schools, 'prevention' is likely to be how they define it (Weare, 1986, 1988a; Crimlisk, 1990; Sharp, 1990; Wallace *et al*, 1990). The recent survey by Meakin and Lloyd (1996) in one medical school, which itself confounded the terms health promotion and disease prevention, found that preventive issues were covered in about half the courses, and that the topics most often taught in detail were screening and immunisation, smoking and alcohol, with exercise, diet, safe sex and accident prevention being taught less often.

However, although prevention is what most doctors understand by health promotion, prevention has itself experienced a mixed history and reputation within medicine. Doctors have long been practising 'preventive medicine' in the form of routine immunisation and screening, particularly in general practice (Foster, 1986; Fullard *et al*, 1984). Throughout the 70s and 80s research suggested that the majority of GPs were said to be offering 'opportunist advice' (Stott and Davis, 1979; Boulton and Williams, 1983, 1986) in their normal consultations, with such advice cropping up in 74% of the GP consultations in the UK (Department of Health, 1992; Sullivan, 1988). Patients seemed both to expect and to be in favour of such interventions (Wallace and Haines, 1984; Sullivan, 1988; Hughes, 1988). Studies suggested that, on the whole, prevention in Primary Care was at that time largely successful, with many interventions producing positive results (Sanders, 1992; Roland and Dixon, 1989; Siem, 1986, Wallace, Cutler and Haines, 1988), especially in the case of

smoking cessation (Jamrozik *et al*, 1984; Wrench and Irvine, 1984; Williams, 1987; Killoran, 1993).

In 1990, as part of the 'new contract', the British Government introduced an obligation on Primary Care practices to set up health promotion clinics and regular preventive check ups, followed by 'lifestyle' consultations, to be carried out by GPs or practice nurses for new patients or those not seen within the last 3 years. For these specific activities GPs were paid a fee (Waller *et al*, 1990; Chisholm, 1990). On the whole this approach has not gone down well with GPs, who have tended to resent its imposition, and have become more cynical and disillusioned about prevention since that time (Redfern, 1994; Calnan *et al*, 1994; Orme, 1994). There has been much debate about the effectiveness of this approach, for which there is thought to be little real evidence (Robertson, 1992, Gibbens *et al*, 1993; Meldrum, 1991; Thomas, 1993; OXCHECK Study Group, 1994; Family Heart Study Group, 1994). The clinics and the 3 year check ups have now been abandoned for existing patients, although they remain for new patients. In many practices, there is now a tendency for doctors to delegate completely the day to day responsibility for preventive activity to nurses (Calnan *et al,* 1994).

As a result of the experience of having it imposed on them, and in view of what some see as the equivocal evidence on effectiveness, British GPs' feelings about prevention appear now to be more mixed than they were a decade ago. Some studies have suggested GPs are still in favour of prevention (Coulter and Schofield, 1991), but others suggest they are at best ambivalent, and at worst negative (Hannay, 1993; Rose, 1993). Surveys have reported low morale, stress and exhaustion, especially among 'fundholding' GPs who have had their responsibilities vastly extended by the 'new contract' (Kaufman, 1990; Sutherland and Cooper, 1992). Research on doctors in the United States suggests a very similar picture of mixed feelings about prevention, and in particular a strong concern over its effectiveness (Sobal *et al*, 1986; Wechesler *et al* 1983; Nutting, 1986).

In addition to the concern about effectiveness, doctors have long had other reservations about the effects of preventive medicine. A recurrent issue is whether prevention reaches the 'at risk' people who need it most (Rose, 1981; Moser, 1986; Gillam, 1992; Shewry, 1992; Jones *et al*, 1993). The phenomenon of the 'worried well' who consult as a result of preventive campaigns, while those who really need the help do not respond, has been copiously documented (Barsky, 1988). It has also been suggested that screening can raise the anxiety levels of patients (Stoate, 1989). An interview survey of medical teachers by the author in the mid 1980s identified a range of concerns about prevention, including the familiar ones about its effectiveness, and also its perceived negativity, its 'authoritarian' nature, and the inappropriateness of asking highly trained doctors to engage in what was viewed by some as a very simple activity (Weare, 1986). Surveys in the US looked at some

of the further barriers to implementing prevention, and cited lack of time, lack of space, inadequate reimbursement and unclear recommendations (Gemson and Elinson 1986; Green and Kreuter, 1991).

Hospital doctors have always appeared to be markedly less knowledgeable about risks to health, and less positive and effective at prevention, than their GP counterparts. For example, studies have shown that hospital doctors tend not to be skilled in assessing the health risks on incoming patients, such as taking and recording drinking or smoking histories (Barrison, Viola and Murray-Lyon, 1980; Bairstow *et al*, 1993). In contrast, hospital nurses have for some time been taking their role in prevention seriously (Wilson Barnett and Latter, 1993; Wilson Barnett and Macleod Clark, 1993).

So, prevention constitutes an important part of health promotion, and is an approach which makes sense to doctors, even if they have reservations about it. It is clearly then an important issue for this research to consider.

- ***This thesis will examine the extent and nature of teaching about prevention in the medical curriculum, and at staff attitudes towards prevention.***

THE RATIONAL EDUCATION MODEL

Assumptions

We turn now to an approach which is not nearly so well known in medicine as is prevention, but has had a strong influence in health promotion. Most taxonomies of health promotion include an approach they term 'educational' (Draper *et al*, 1980; French, 1990; Naidoo and Wills, 1994). However, many educationalists, including the author, have claimed that education can be a good deal more sophisticated than the model that is usually so entitled (Tones, 1987b; Weare, 1992). For this reason this thesis will use the more precise title of 'rational educational approach', to acknowledge that there are other models of education.

The underlying belief of the rational educational approach is that people are basically rational, their behaviour, including their health related behaviour, driven by logically derived principles (Williams, 1984). Change is assumed to be a straightforward and uncomplicated process: people simply need the right information and then they will make the right decisions and choices (Baelz, 1979). The model is premised on a widely held assumption about education, that it is mainly a matter of intellectual and cognitive development, which is brought about by the transmission, memorisation and application of facts, an assumption which would appear to be particularly prevalent in medical education (Coles, 1985a; Coles and Holm, 1993).

Strengths

The rational educational approach has many strengths. It is straightforward, and provides a clear and uncompromising framework for action. It has some ethical validity too: people have the right to information on which to base their actions. So no education programme could be considered complete without a sound underpinning of solid fact. Considerable and valuable work on attitude theory has shown that attitudes have a strong cognitive dimension. People's behaviour and opinions are indeed partly shaped by their beliefs (Fishbein and Ajzen, 1975), including those that relate to health (Becker, 1974), so helping people to think differently about the world constitutes a valuable technique for helping them change (Ellis, 1980). The approach can also be said to have the force of pragmatism. Education often has to precede policy changes, as people need to be prepared to accept an idea, and legislation only succeeds where the majority accept the basic correctness of the thinking behind it (Dillow *et al*, 1981).

The rational education model and medicine

The rational education model, and its underlying assumptions, is perhaps the most commonly used model among 'progressive' doctors. Such a model underlies most progressive doctors' view of 'patient education', which assumes that what patients need is facts, for example about their condition or its treatment, in the form of information services, help lines, leaflets, videos, posters and one to one lectures, with an opportunity for 'questions' (Fowler, 1985; Ley, 1990). There is however much confusion within medicine about what can be achieved simply by giving people factually correct information. It is often taken for granted by many doctors that this approach will lead to compliance and thus behaviour change in a medically approved direction, an assumption to be found, for example, in the work of Ley (1990). In fact those who follow it for this reason are likely to be disappointed, as people do not in fact change so easily, their behaviour being influenced by other factors than the purely cognitive.

According to the 'pure' form of the rational educational model, non compliance does not matter, and should in fact be construed an alternative form of success (Baelz, 1979). The primary aim of the rational educational approach is the autonomy of the learner, including autonomy from the teacher. It elevates the principle of voluntarism above all others: the desired outcome of this approach is free choice, and at any point the patient must be free to choose what they do, including choosing outcomes of which the educator may not themselves approve. Such an 'educationally correct' outcome, is probably not one that many doctors would find comfortable.

Shortcomings

The rational educational approach has many shortcomings. It simply does not describe what most people are like most of the time, nor does it provide an adequate toolkit to help them

change. Its view of human motivation is too simplistic. People are not solely or even mainly rational: they are creatures of emotion and habit, and strongly shaped by the economic, social and psychological contexts in which they live. Case studies of health education interventions (Cleary *et al,* 1985) and large scale reviews and of health promotion initiatives (Gatherer *et al,* 1979; Liedekerken, 1990; Veen, 1995) have shown that most unhealthy behaviour does not spring from a knowledge deficit: people can know what is 'good' for them in terms of their physical health at least, but still be unable to respond to these healthy messages. Even the most motivated find healthy lifestyles hard to sustain (Spellar and Priest, 1992).

So, although 'rational education' is certainly ethically 'pure' and contains some elements of good sense, it is basically too naive. To redress its shortcomings we need to turn to other models and approaches.

THE BEHAVIOUR CHANGE MODEL

Behaviour change

Behaviour change approaches tend to bypass the inner person, including the intellectual, decision making, choice making side, and go straight for behaviour.

The judging of interventions in terms of their behavioural outcomes is pre-eminent in prevention and health promotion (Green and Kreuter, 1991), particularly in medical circles (HEA *et al,* 1989; Family Heart Study Group; 1994; OXCHECK Study Group, 1994). Most health promotion research collects data about behaviour, and most interventions have as their standard of evaluation that behaviour be changed as a result (Gatherer *et al,* 1979; Liedekerken, 1990; Veen, 1995).

The popularity of the behaviour change approach in health promotion and medicine may be partly due to its face validity: behaviour is indeed central to health. Although luck and genetic inheritance play a part in how healthy or unhealthy a person may be, few would deny that much ill health is behaviourally related. The classic examples are heart disease and cancers, which research strongly suggests are caused by smoking, a high fat diet, and in the case of heart disease, lack of exercise (Jacobson *et al,* 1991; DoH, 1992).

The pre-eminence of behaviour change in health promotion, especially among those who work in medical contexts, may also be because those who practice it are keen to gain the credibility it offers. In these endeavours, behaviour has the advantage of being more easily observed and measured than more nebulous concepts such as beliefs, attitudes or values. It is perhaps no coincidence that the preferred term for the psycho-social sciences in the

official policy documents of medical education tends to be *'behavioural science'* (GMC, 1987b, 1993).

The behaviour change approach tends invariably to be based on the positivist, quantitative paradigm of scientific enquiry (Weston, 1997a), where, in the health context, the randomised control trial has long been seen as the 'gold standard' in this milieu (Weston, 1997b; Jelinek, 1991), the only research strategy that meets proper standards of scientific proof, objectivity and validity (Cochrane, 1971; Donaldson and Donaldson, 1993). Recommendations for action in such health promotion approaches tend to use a hard edged approach, and set 'performance indicators' based on rigorously specified objectives that can be measured numerically (DoH, 1993).

So, behaviour change is a popular goal for those who wish to promote health. But many, including many doctors, fail to realise that the goal, however desirable, is not easily achievable. Many doctors operate on the naive assumption that behaviour change can be achieved by them simply telling people what they should do, and warning them of the dire consequences if they do not (Collins, 1984; Weare, 1986). There is even less evidence for the effectiveness of this approach than there is for that of 'giving them the facts' (Gatherer *et al,* 1979; Liedekerken, 1990; Veen, 1995).

The 'tell them what to do' approach is often mistakenly labelled 'behaviourist'. In fact few doctors could be said actually to use a behaviourist approach, which, as we shall see, is complex and sophisticated, potentially patient centred, and valuable for health promotion.

Behaviourism

'Behaviourism' could be regarded as the empirical, scientific offspring of behaviour change. The focus of behaviourism is, unsurprisingly, on behaviour and behaviour change, or more accurately, behaviour modification. Its central belief is that to understand people is simply to observe their behaviour and the cues that triggers it, and that this is as far as any analysis needs to go. Where the rational educational approach sees behaviour as the product of inner beliefs, the behaviourist approach turns the equation on its head, and suggests that people are essentially made up of learned impulses, habits and responses: their feelings, beliefs and motivations are products of these behaviours, not the other way round (Skinner, 1953).

In behaviourism the task of the educator becomes one of modifying behaviour by shaping the context in which people learn, by, for example, removing distractions, making the cues for action clear, determining where the learner is and starting from there, progressing in small steps, with a system of graded rewards for correct responses, and ignoring incorrect ones (Bandura, 1970; Poteet, 1973). Thus will people acquire new behaviours, eventually habits, from which inner convictions will then spring. In contrast to the rational educational

approach, the desired outcomes are preset, describable in terms of behavioural changes. If these do not occur then the intervention is deemed to have failed.

It is a misunderstanding of the approach to assume that it is inevitably top down and authoritarian, with goals being set by the professional. In practice, behaviourist programmes are usually voluntaristic, and can be, and often are client or patient centred. Many of the most successful behaviour modification programmes are those which people devise for themselves, with or without the help of professionals, to get their behaviour under their own control and to help them reach their own goals (Watson and Tharp, 1985; Kanfer and Goldstein, 1986).

Behaviourism would not be so popular if it did not have strengths. It has much to offer health promotion, and indeed many of those who malign it, turning instead to 'social change' models are in fact using its precepts. Behaviourism reminds us of the importance of the environments, contexts and 'settings' in which people operate in shaping their attitudes and behaviours, a key precept of social change approaches of health promotion. Behaviourism also reminds us of the significance of role modelling in shaping health. The extent to which doctors see themselves as role models for health and look after their own health, both on their own account and as an example to their patients, is of great concern to all involved in health promotion. All these issues will be looked at in more detail later in this chapter.

The approach also scores highly on pragmatism: on the whole, it works. Through it educators and psycho-social scientists have discovered important lessons about how people actually learn and function, and what helps or hinders their change. For example the importance of giving the learner clear cues, and of using reward rather than punishment to reinforce desired responses are vital principles which all forms of education do well to employ (Fontana, 1981).

Limitations of behaviour change

Recognising that behaviour is important and that behaviourism has value does not mean that we have to subscribe to these approaches in their entirety. The behaviour change and behaviourist approaches can be said to fail on the principle of validity, because they too do not give an adequate account of what people are like. The gestalt school of psychology demonstrated that even animal learning can employ insight as well as trial and error (Tolman, 1949) and some have claimed that conditioning is not a relevant concept for adult learning (Brewer, 1972). Recognising the importance of behaviour then provides a useful and realistic balance to those approaches which concentrate solely on cognition or affect. But most health promoters would judge that it is balance rather than a supersession, and that there is more to people than their behaviour. It would appear that, while playing due

attention to behaviour and habit, we also have to look deeper and understand their underlying determinants. Knowledge, beliefs, values, emotions do influence behaviour in their turn and need themselves to be the focus of enquiry and of attempts at change. It is to an approach that attempt to tap into these further dimensions that we will turn next.

But, given the importance of the behaviour change approach in health promotion and medicine, the value of behaviourism, and the familiarity of the idea of behaviour change as a goal for doctors, this thesis will look at what medical staff thought and taught about behaviour change, its strengths and limitations.

- ***This thesis will explore the teaching of psychological issues in the medical curriculum, including looking at whether the medical curriculum taught about health related behaviour or behaviour change, and staff attitudes to this issue.***

THE SELF EMPOWERMENT MODEL

Goals

The psychological model that has, for the last 10 years at least, been most in favour in health promotion circles, is that of self empowerment. The term has been used in health promotion extensively and in a variety of senses, some of them fairly vague. This section will look at the concept as it has been specifically defined and explored, particularly by its leading exponent, Tones (Tones, 1981, 1986, 1987b, 1992; Tones and Tilford, 1994; Tones, 1997).

This model underpins the Ottawa Charter's (WHO, 1986b) definition of health promotion as involving, *'the enhancement of the individual with the knowledge, skills and motivation to make competent decisions about their health.'* The WHO (1986b) claims that:

> *To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs and to change or cope with the environment.*

The empowerment approach is as keen on autonomy as the rational educational model, and is almost invariably used, or intended to be used, in a client centred way. However those who espouse it tend to see this approach as more realistic about the nature of autonomy, and more proactive in the methods appropriate for achieving it than is the rational educational approach. Self empowerment attempts to address some of the shortcomings of both the rational educational and behaviour change models. It builds on the rational educational approach in recognising the importance of information, and on the behaviour change

approach in recognising the importance of habits and skills, but it takes a more holistic approach to the human mind than either of these models, by acknowledging the importance of affect as well as behaviour and cognition (Tones, 1992).

Self empowerment draws on the work of health psychology which has conceptualised and named a whole range of inner beliefs about the self in relation to the world, such as 'self efficacy' (Bandura, 1977), 'health beliefs' (Becker, 1974) and 'locus of control' (Wallston and Wallston, 1982). These beliefs, when negative, are thought to cause people to feel passive, powerless, worthless, and thus do little or nothing to promote their own health. People can be fettered by their own unhelpful beliefs, restricted through a lack of skills, and disempowered by social circumstances they have not the confidence or the competence to tackle (Graham, 1984, 1993). Those who favour the self empowerment model tend to hold the rational educational approach inadequate for not recognising the pressures people are under and the constraints which prevent some of them from believing that they are free to make 'healthy choices'. The assumption of the rational educational approach that people can change freely simply by being given the facts is seen as 'victim blaming' (Tones, 1981; Tones and Tilford, 1994).

Techniques

So the self empowerment approach sees people as needing more active help than simple presentation of facts if they are to be autonomous. This need for a proactive approach applies particularly to the young, who are seen as in need of strong guidance and a clear lead if they are to realise their potential. Where the rational educational model takes autonomy as given, the empowerment approach sees it as the goal, an end point rather than a starting point, not something people are, rather something they need positively to be helped to become, through empowerment techniques.

Empowerment techniques use the energetic educational methods that draw to a large extent on the worlds of personal development (Nelson Jones, 1991) and counselling (Burnard, 1989; Corney, 1991). These techniques are thought to aid the growth of autonomy by tackling the inner and outer forces that block it. In the empowerment approach, the professional takes the role of 'facilitator' working in partnership with clients, or patients. Activities include helping people clarify their beliefs and values, examine and understand their emotions, build their self esteem, achieve a feeling of control, get control of their habits and develop their personal skills (Hopson and Scally, 1981; Anderson, 1986, 1988; Tones, 1986). Groups are used as well as one-to-one approaches (Satow and Evans, 1982; Woolfe and Fewell, 1991; Cherry *et al*, 1991), including self help groups. Active, and often experiential, learning methods are favoured (Rogers, 1983; Brandes and Ginnis, 1986; Henderson, 1989). Within the world of heath promotion and health education the overall methodology has been perhaps most fully developed in the context of health education in

schools (Baldwin and Wells, 1981; WHO, 1993; Metcalfe *et al,* 1993; Weare and Gray, 1994).

Self empowerment in medicine

There is some evidence of an interest in this approach among those who would develop health promotion in medicine. The most recent HEA statement on health promotion in the undergraduate medical curriculum, in its description of goals for the medical curriculum, uses the word 'empower', and appears to be genuinely employing a concept of 'facilitation' as well as 'information giving' in its statement of goals for the medical curriculum: *'to empower people, through information giving and facilitation, to ask questions and challenge ideas in order to help them reach personal decisions'* (Pringle, Fragstein and Craig, 1997).

On the whole, medicine has not made much use of the specific term 'empowerment', but the the principles that inform the concept can be found in the growing acceptance in medicine of the value of counselling (Burnard, 1989; Corney, 1991; Davis and Fallowfield, 1991). Medical education too is showing an interest in counselling, for example *'Tomorrow's Doctors'* (GMC, 1993) believes that all medical schools should learn what it calls *'skill in communication'* because it is *'at the heart of counselling'*.

So, given the centrality of this model for health promotion, this thesis will seek evidence for an understanding of and teaching about self empowerment in the medical curriculum.

- ***This thesis will examine the extent and nature of teaching about self empowerment approaches in the medical curriculum, and at staff understanding of and attitudes towards empowerment.***

SOCIAL MODELS

The need for a social perspective

We have already seen, when we examined the concept of holism, that health and illness are not just matters for the individual, they are, at least in part, social phenomena, with social determinants and consequences. Many have argued that in the promotion of health, individual personal change is a necessary but not a sufficient condition (Doyal, 1983). As well as changes to the knowledge, skills and attitudes of individuals, changes in the social framework are necessary (Caplan, 1997). Following the vivid metaphor proposed by Zola (Zola, 1970, cited in McKinlay, 1979) this approach is often described as 'refocusing upstream', looking for underlying causes of ill health in social conditions, seeing health as not just determined by the lifestyle of the individual but strongly shaped by the

environments in which people live and work, and by the social and economic forces which mould their experiences, opportunities and choices. This approach to health promotion, sometimes encompassed by the phrase 'the New Public Health' (Ashton, and Seymour, 1988; Martin and McQueen, 1989) recognises the need to address the structural and political contexts which shape the health of individuals and communities.

The radical social change model

Within the 'social' approach to health promotion, various shades of radicalism exist. Those at the more radical end of the spectrum tend to have a particular view of the nature, origins and solutions of the key health problems. As we have seen, many in health promotion have a concern with equity (WHO 1986b; Whitehead, 1991; Tones and Tilford, 1994), which has been shared by medicine (BMA, 1987; Stott *et al*, 1994). The more radical however see the distribution of wealth and power as the dominant issue for health promotion, the issue which underlies and determines all others (Hart, 1982). They thus focus predominantly on health inequalities, in particular the differences in health between rich and poor (Doyal, 1983; Townsend *et al*, 1992; Pearson *et al*, 1993), and less often on other distinctions, such as race (Brent Community Health Council, 1981; Mares *et al*, 1985; McNaught, 1987).

Like those who espouse self empowerment, those who believe in radical social change acknowledge that different groups have attitudes and beliefs such as 'low self esteem', 'external locus of control', 'fatalism' or short term hedonism', which contribute to their problems: however they see these attitudes as symptoms rather than causes of the problems people face, and indeed often as realistic assessments of the position in which the less powerful find themselves (Mitchell, 1984). They claim that to focus only on individuals is to 'blame the victim' not tackle the root cause of ill health (Mitchell, 1994; Rodmell and Watt, 1986; Davison, Frankel and Davey Smith 1992). As such, they find the self empowerment approach, used on its own, still a form of 'victim blaming'.

Given their analysis of causality, those who espouse radical social change hold that only political actions that challenge and change the structure of the distribution of wealth and power are likely to bring about real changes in health. They argue that to imagine that all health related problems can be solved by consensus and voluntarism is to be dangerously naive about the causes of ill-health in society (Mitchell, 1994; Rodmell and Watt, 1986; Davison, Frankel and Davey Smith, 1992), and are thus keener on the idea of compulsion than those who espouse 'softer' analyses of the problem. They tend to see those with commercial and industrial interests as in need of strong control via at least strong economic incentives, and possibly compulsion, coercion and legislation (Mitchell, 1994; Jacobson, 1991). They say that it is unrealistic to expect self restraint from those in positions of power who are able to shape society for their own profit, while exploiting and oppressing those without power, for example to work for low wages in dangerous occupations (Watterson,

1986) and to rely on the instant pleasures of unhealthy products such as cigarettes, alcohol and packaged food in an attempt to alleviate the misery of their situation (Graham, 1984, 1993; Hart, 1982).

Those who favour radical approaches would also see the minds of the victims of such a system as potentially clouded by 'false consciousness', and although they would not advocate coercion in their case, would suggest that some very dynamic approaches may need to be employed to help shift erroneous and damaging beliefs (Hart, 1982; Mitchell, 1984), a process which, after Freire (1974) has been called 'conscientisation' or, more usually, 'consciousness raising'.

The social empowerment model

One problem with the more radical end of the spectrum is that it can easily become as authoritarian, top down and coercive as the models it claims to replace (Beattie, 1991). A model which attempts to use the insights of the radical social change model on the political and structural causes of health and disease, and its idea of 'consciousness raising' (Wallerstein and Bernstein, 1988) but underpin them with the active educational approaches of self empowerment and the principles of genuine community participation, accountability and ownership, is that of social empowerment.

The fundamental principles that were discussed in the context of self empowerment, such as starting where people are, consultation, and the role of the professional as facilitator apply equally well to social empowerment (Hubley, 1984; Richardson and Bray, 1987; Adams and Smithies, 1990; Kickbusch, 1981; McEwen, Martini and Wilkins, 1983; French, 1990). Social empowerment shares the insight of self empowerment and radical social change approaches, that the provision of facts is only a very small part of the educational process, and, that autonomy has to be achieved rather than being given, and that professionals have an active role to play in helping people to become autonomous. Social empowerment approaches in health promotion attempt to bring together self empowered individuals, with the knowledge, skills and attitudes that can change their personal circumstances, challenge political structures, and create the kind of healthy environments that communities themselves wish to have (Catford and Parish, 1989; Green and Kreuter, 1991).

As with self empowerment, it is perhaps unlikely that medical education will make much use of the concept of 'social empowerment', so called, but the principles behind the approach may make an appearance under other names, and in particular in discussion of the relationship between the medical profession, both with other professions and with patients, which is an issue that will be discussed later in the chapter.

The role of health professionals in social change

Both the radical social change model and the social empowerment model see health professionals as having an active role in bringing about social change. They suggest that, if health professionals are not to contribute to the problems of society by passive collusion, they need to take an active role in opposing the forces of ill health. They see health professionals as potential activists on behalf of the oppressed, getting out into the public arena and using a variety of means to lobby and advocate for health and mediate between the powerless and the powerful (Campbell, 1984; Tones, 1987b; WHO, 1986b; Baric, 1988; Marshall, 1992; Stutor, 1993; Kemm and Close, 1995). Health professionals are called on to refocus attention upwards on the decision makers rather than downwards on 'victims', who have for too long been regarded as 'the problem'. They are seen as having the social power to understand and expose the true determinants of health. An obvious example is the tobacco industry, with what many would see as their hypocritical sponsorship of activities with wholesome and healthy images, such as sports and the arts, supported by the economic and political interests that fail to curb their activities, in what Taylor (1984) called a '*smoke ring*' of collusion.

There appear to be some indications that doctors are considering their role as agents of social change, and making use of the fact that, for good or ill, they are among the most powerful and highly respected figures in society, in a strong position to influence the policy decisions which affect health (Tudor Hart, 1988; Simons-Morton and Simons-Morton, 1987). The health professions, including doctors, appeared to have become more 'radicalised' during the 80s and 90s, seeing part of their role as being to point out that health problems have political and structural causes and solutions (BMA, 1987). It has indeed been the medical profession who have played a significant part in the relative success of the anti-tobacco lobby (BMA, 1986).

Healthy Public Policy

All of those who concern themselves with social approaches to health promotion recognise that the public policies that coordinate and drive social action are among the key determinants of health (Milio, 1986). In recognition of this, the international agencies involved in health promotion have spent a good deal of effort in policy creation, for example the WHO policy document 'Targets for Health for All' (WHO 1985) unanimously adopted in 1984 by the 32 European Member States of WHO. Such policies provide the framework for the legislation and regulation that govern behaviour and fiscal measures such as systems of taxation, incentives, subsidy and pricing policies that make healthy environments possible. Clearly such policies cannot be divorced from those that govern the rest of society, and at this level health promotion overlaps with all the other major sectors, not only the health services but others such as social work, housing, education, environmental health, and planning.

Social audit and the role of epidemiology

All comprehensive models of health promotion recognise that, before taking action, some form of social audit which gathers information to enable a rational plan of action to be made is essential. Green and Kreuter (1991) have made much of the need for this activity in their highly complex planning model (termed Precede- Proceed), in which they include *'social diagnosis', 'epidemiological assessment', 'etiology: assessing the determinants of health' 'environmental diagnosis'* and *'policy diagnosis'* as necessary steps. In the health service, 'needs assessment' has also become routinely accepted as vital in the running of a well planned system, which can prioritise in a rational manner.

A key tool in carrying out such auditing and social diagnosis is the science of epidemiology. In the recent HEA policy document (Pringle, Fragstein and Craig, 1997) such issues figure prominently among the core topics suggested as appropriate in a health promotion curriculum for medical students. The GMC policy document, *'Tomorrow's Doctors'* includes a grasp of epidemiology, and *'the ability to identify individuals at risk and to take appropriate action'* as among the *'attributes of the independent practitioner'* it is keen to encourage. (GMC, 1993, pp 25-26).

Social issues in medicine

So, the recognition that health, illness and health promotion are at least in part social phenomena has given rise to at least two major models of health promotion, radical social change and social empowerment, and a range of related issues, including the role of the health professional in taking social action.

The need to include a social focus in the study of health and disease is well recognised in policy documents that relate to medical education. In 1987, emphasising the importance of teaching about social issues, the GMC claimed that *'nearly all illness stems, directly or indirectly, from the environment human beings create for themselves, in the form of the society in which they live'. Tomorrow's Doctors'* places great emphasis on the need to teach students about the *'social, cultural and environmental factors which contribute to health or illness'* (GMC, 1993, p.25) and to shift the focus in medical education from being solely on the individual to include the population. Interestingly, this document links this population focus directly with health promotion when outlining one of the *'attitudinal objectives'* it sees as key for students to acquire, namely:

> *willingness to use his or her professional capabilities to contribute to community as well as to individual patient welfare by the practice of preventive medicine and the encouragement of health promotion...*
>
> (GMC, 1993, p.15).

The HEA core curriculum for medical students (Pringle, Fragstein and Craig, 1997) devotes as much space to outlining the competences involved in *'community health promotion'* as it does to those involved in *'individual and the family health promotion'*.

However, as Tudor Hart (1988) has pointed out, doctors, with their positions of relative wealth and security, tend naturally towards conservatism, especially on issues that affect their role (Ewan, 1987). Ewan (1988) found that senior medical students were less likely to recognise social factors as determinants of illness than they were when they started their training. There is, outside of general statements of intent in policy documents, a notable lack of published literature on the theory and practice of teaching social issues to medical students, in contrast for example with the huge literature on 'process' issues in medical education, such as problem solving or critical reasoning, and some content areas such as teaching communication skills. This dearth of literature is even more marked in the case of teaching them about social change. In the mid 1980s, a few isolated individuals attempted to include some rather mild teaching on such issues in some medical schools (Joffe and Farrant, 1987; Weare, 1990b), but there would appear to have been no further instances of such an approach since then. So social issues, especially approaches to social change, may meet with more resistance, or lack of interest, in medical education than the educational and psychological models we have looked at so far.

- ***This thesis will look at the extent and nature of teaching about the social issues in the medical curriculum, and staff attitudes towards social issues.***

INTEGRATED APPROACHES

Integration in health promotion

Although, for clarity, we have so far in this chapter tended to look at various models of health promotion in isolation, in practice, as we have already indicated, health promotion has moved on from the rather static 'war of the models' debates that characterised health promotion theory in the 1980s (Catford and Nutbeam, 1984; French and Adams, 1986). Those who are now trying to put health promotion into practice, as models for action, for evaluation, or for planning, now tend to use more 'eclectic' approaches, bringing together and integrating models as appropriate to the circumstances.

The WHO said, *'health promotion combines diverse but complementary methods and approaches'* (WHO, 1986a), and this agency has devoted a great deal of intellectual effort to bringing together and explicating appropriate principles and approaches for the study of health in general and health promotion in particular. Building on earlier documents, especially the Alma Ata declaration of 1978 and 'Concepts and Principles of Health

Promotion' (WHO, 1986a), the Ottawa Charter (WHO, 1986b) put together what has become for many the ultimate recipe for the ingredients for the health promotion 'cake'. It suggested that such a level of consensus has now been reached about health promotion that the theory outlined in the charter can be called a 'concept'. The Charter explores this concept, setting out five areas for action to promote health, which cover developing healthy public policy, the establishment of supportive social and natural environments, community action, the enhancement of the individual with the knowledge, skills and motivation to make competent decisions about their health, and the reorientation of the health services towards health promotion. The Ottawa Charter provided the framework for most of the debates which followed, and in many circles the principles it outlines are now taken as read.

The 'settings' approach

Perhaps the most fully worked version of the integrative approach to health promotion in practice is the 'settings' approach.

Since the Ottawa charter outlined the composite concept of health promotion in 1986, WHO initiatives have concentrated more on the detail of its social and community implementation, focusing in particular on the need for 'supportive social and natural environments' (Dean and Hancock, 1992), often summarised as the 'healthy settings' approach (Health Promotion International, 1991; Grossman and Scala, 1993). The 'settings approach' has directed attention away from the health attitudes and practices of individuals to look instead at the development of healthy environments, where, for the individual, healthy choices are the easy as well as the rational choices. The approach recognises that health is the product of a myriad of interconnected and interacting physical, social and psychological factors. It therefore takes a holistic approach to action, which attempts to shape a total context that is conducive to health, and where not only the physical environment but the ethos and relationships provide a climate in which the good health of all who live, work and play there can flourish. The WHO has championed this shift towards shaping healthy settings within which people can begin to realize the ideal of a healthy lifestyle (WHO, 1991). It masterminded several related initiatives, including 'healthy cities' (Kickbusch, 1989) 'healthy schools' (Young and Williams, 1989; Commission of the European Communities, 1990b) and 'healthy hospitals' (Health Promotion Authority for Wales, 1989; Spiros and Sol, 1991; HEA, 1993).

Beyond eclecticism: the rise of the 'metamodel'

The WHO's attempts to move to using integrated approaches to health promotion, such as the Ottawa Charter (WHO, 1986b), 'Concepts and Principles in Action' (WHO, 1987a) and, more generally, the 'settings' approach, have been characterised more by eclecticism than coherence, and take something of a 'shopping list' approach, setting the various dimensions and issues of health promotion beside one another, but with no apparent attempt to evolve a

theory of how they relate to one another.

There have been some attempts to suggest how different domains can be articulated and integrated into what might be termed a 'metamodel'. For example, the Health Action Model (Tones, 1987a) is one of the most popular models currently in use in the UK, while Green and Kreuter's 'Precede Proceed' model already touched on (Green and Kreuter, 1991), makes a similar attempt from a US background. These metamodels attempt to relate the various psychological, social and environmental elements that shape health actions and processes in a coherent, systematic and conceptually sound manner, making some claims as to cause and effect. They claim to provide all encompassing models for action, which acknowledge previous debates and draw on the more purist models, according to both circumstances and appropriateness and a provide clear set of principles for action.

Integration in medical education

This drive for integration that has characterised the theory of health promotion in recent years would appear to fit with a similar impulse in medical education (Morgan, 1980). Concerns about the problem of curriculum 'overload' have continually been voiced for over a century, especially by the GMC (GMC, 1957, 1967, 1980, 1993). A Royal Commission on Medical Education in the mid sixties, known usually as the Todd Report, recommended strongly that medical schools integrate their curricula, and this call for integration has been reinforced in almost all policy documents since then (GMC, 1980, 1993).

The integrated approach is not without its difficulties. The GMC notes that such integration is '*costly in time and effort and therefore difficult to contemplate when resources are scarce*' (GMC, 1987b, p. 8).

The drive for coherence in medical education

Such attempts to produce coherence and higher order integration of ideas is echoed in the medical education literature, where many of those who specialise in the theory of medical education have long been urging medical schools to see their task as helping students acquire deep understanding and the ability to inter-relate and integrate ideas in a holistic way (Entwistle and Ramsden, 1983; Harden, Sowden and Dunn, 1984; Coles, 1985a). However, all those who write about the issue agree that this task is a long way from being realised, and for the time being, medical education is still seen by many students as a set of unrelated subjects, and the task of learning medicine is the memorisation of vast numbers of discrete facts. So, it may be that medical education is by no means yet ready for 'metamodels'.

Integration in health promotion in medical education

The issue of integration is of direct relevance to the teaching of health promotion in medical

education. At present it would appear to be the case that the central ideas of health promotion are more likely to be found in the psycho-social sciences and in Public Health than in other parts of the curriculum (GMC, 1987b; Weare, 1990b). However, a GMC report (GMC, 1987b) emphasised that what it called 'prevention' should not be restricted to what was then termed 'community medicine', and 'behavioural sciences' but should be taught in an integrated way, across the curriculum, including in clinical subjects. It reported that this approach had met with some success, with these subjects combining under titles such as communication studies, health planning, and community studies. The HEA's policy document on health promotion in medical education also recommended an integrated approach to the teaching of health promotion (Pringle, Fragstein and Craig, 1997). Those who have made some attempt to develop health promotion across the medical curriculum (Weare, 1988b; Orbell and Abraham, 1993; Taylor and Moore, 1994) have endorsed the need for its widespread integration and coordination across a wide range of subjects, particularly but by no means exclusively in Public Health Medicine and the psycho-social sciences.

So the issue of integration is of relevance to health promotion in medical education in a wide variety of interrelated ways.

- ***This thesis will explore the issue of integration in the medical curriculum in question. This will include looking at:***
  - ***whether medical students were taught about integrated approaches to health promotion***
  - ***whether health promotion was integrated into courses, and if so, which***
  - ***whether the specialties that are most likely to teach health promotion were integrated into other courses, and with one another.***

EMPOWERING RELATIONSHIPS IN MEDICINE AND HEALTH PROMOTION

Rationale for looking at relationships

We have seen that medicine does not make much use of the specific term '*empowerment*'. This does not necessarily mean that the principles of empowerment have no meaning or resonance in medicine. This section will explore the implications of empowerment models for medicine, and the overlaps between debates about the principles behind empowerment and debates that are current in medical practice about the relationship of doctors to other professionals and to their patients.

THE ROLE AND POWER OF THE DOCTOR

From de-professionalisation to facilitatation

The types of development in both medicine and health promotion discussed earlier, such as empowerment and social change, demand a major change in the role of the health professional, removing some of their traditional power and mystique. This tendency has in been apparent for some time in discussions about the role of health professionals in general, and doctors in particular.

In the 70s there was a wholesale move to 'de-professionalise', the leader of which was perhaps Illich (1975). This movement saw the professions, especially medicine, as a pernicious influence, servants of capitalism, disabling and disempowering those whom they claim to serve, and through iatrogenesis, causing rather than solving health problems (Johnson, 1972; Freidson, 1970; Navarro, 1976; Ehrenreich and Ehrenreich, 1978). Doctors came in for a vast amount of criticism, including a strong feminist critique over what was perceived as patriarchal control by male doctors over women's bodies (Mitchell and Oakley (eds) 1976; Cartwright, 1980). The implications for health promotion were that, according to the de-professionalisers, doctors do not have a part to play, and should stick simply to the technical tasks of diagnosis and surgical and pharmacological treatments. Patients are responsible for their own health and should keep away from doctors as much as possible if they want to stay healthy, while the community should look to itself rather than to the professions for direction and leadership in its attempts to reach a state of positive health.

Since then the mood has changed somewhat, and professionals, with their training and knowledge are, for the most part, seen as having an important role to play in the total scheme of things. Many of those writing today however see it as vital that professionals recognise the concerns that lead to the calls for 'deprofessionalisation', and use a 'bottom up', empowering, approach (Seedhouse, 1986). The role of the professional working within a social empowerment model is to act as a resource for the community, listening to and learning from individuals, groups and communities about their needs, encouraging their participation, and working alongside them to realise their aspirations (Pearson *et al*, 1993; Popay and Williams, 1994; Tones and Tilford, 1994). Using some memorable metaphors, Werner (1978) conceptualised it as turning the traditional hierarchical 'pyramid' of power on its side, and instead of having health professionals, lead by the doctor, dominate the process, to have them working alongside people, *'on tap, not on top'.*

The HEA report on health promotion in the undergraduate medical curriculum recognises the significance of the social empowerment approach for the role of the doctor and for medical education. It sees the skills of *'negotiation, influencing, networking and alliance*

building' at community as well as the individual level as essential health promotion skills for medical students to learn (Pringle, Fragstein and Craig, 1997, p.3). It emphasises that students need to be taught to '*know that communities need to be involved in decision making about key health and health care issues'* (*ibid*, p. 8).

Healthy alliances

The move towards healthy public policies, discussed earlier, reminds us just how many agencies and interests are involved in health promotion. Many in health promotion consider that the sheer range of activities involved in health promotion, and myriad levels at which it takes place mean that it is in a very real sense 'everybody's business'. Health promotion is today usually seen as an activity which spreads right across the community and takes place in a wide range of settings. Thus many publications, including documents supporting the 'Health of the Nation' (DoH, 1993) call for 'healthy alliances' of all those interested parties, recognising that health is an intersectoral activity, to which almost everyone has a contribution to make, lay person and professional, inside and outside the health services (Downie *et al,* 1990; Powell, 1993). The WHO have written particularly forcefully on the issue: health promotion, and indeed health care in general, are seen by them not as the special provinces of any one sector or profession, but as ideals towards which all must contribute in a multi-disciplinary and intersectoral way (WHO, 1988b).

The HEA's core curriculum for health promotion in medical education suggests that medical students should be taught to understand the need for *'healthy alliances'* and *'intersectoral collaboration'* and, to '*be aware of methods of collaboration'* between *a range of agencies in health promotion'* (Pringle, Fragstein and Craig, 1997 pp 6-7).

However, some have written, with realism, about the strains of attempting to operate 'healthy alliances', which are not as easy to make function as to write about, given the professional demarcation disputes that can ensue (Prentice, 1991; Ewles, 1993; Nocon *et al*, 1993). Associated with the empowerment of patients, there has to be a reassessment of the various roles of health professionals vis a vis one another, which is an issue to which we turn next.

Teamwork

The notion of 'alliances' implies a certain equality between the parties concerned. As we have already mentioned, traditionally health care has been organised as a top down hierarchy, in which doctors dominate as the 'natural' leaders, supported by nurses, and by other ancillary professions (Willis, 1989; Lupton, 1994). However the health professions allied to medicine have worked energetically in recent years to upgrade their training and to change their own and others' attitudes, and are increasingly demanding to be seen as different but equal. Nurses in particular have expanded their role in health care, to take in

many, and more professional, roles. Many of those working in the health sector feel that the traditional hierarchical structure needs to break down, and be replaced by a more cooperative, genuine teamwork ethic within 'flatter' management structures (Jones, 1986; Baja, 1993). Such a teamwork ethic applies equally to health promotion, where some are arguing that it is by no means obvious that the doctor should always lead (Fowler, 1986; HEA, 1991).

Multi-professional learning

Some, including the WHO (1988b) have suggested that a greater degree of teamwork among health professionals would be facilitated by a more multi-professional approach to their education (Grant, 1987; Linkoping, 1988; Ramon, 1990; Baja, 1993). To the author's knowledge, no UK medical schools have followed the lead of Linkoping in Sweden, and attempted to integrate their curricula with other professions in a wholesale manner. However some small scale approaches, designed to promote greater understanding have been attempted, such as the placing of medical students on nursing attachments, which appears to have positive consequences for their respect for nurses' expertise (Kent, 1991).

Difficulties of doctors with these roles

It would seem likely the medical profession may find this new, empowering, facilitative, alliance seeking, team-member role particularly difficult. As those with the most to lose from a diminution in the power of the professional, and socialised as they are to see themselves as leaders, the role is not one that doctors are likely to find very comfortable (Roine, 1986). It is interesting, for example, that the GMC document *'Tomorrow's Doctors'* (GMC, 1993) places considerable emphasis on the skills of teamwork in its list of *'attributes of an independent practitioner'*, including *'understanding and appreciation of the roles, responsibilities and skills of nurses and other health care workers'*. However, tellingly, the attributes listed include *'the ability to lead, guide and co-ordinate the work of others'*, but there is no mention of the complementary skills of how to be lead gracefully, when appropriate.

The place of the doctor in health promotion

The issue of the reassessment of the role and power of the doctor is of particular relevance to health promotion. One reason why so many typologies of health promotion leave out medicine is the fear that doctors will wish to dominate and medicalise the process, as they are said to do so in many of the domains connected with health (Kennedy, 1981; Zola, 1981; Strauss, 1984; Turner, 1987; Willis, 1989). Once doctors become interested in health promotion, they tend to see it as a natural extension of their empire of influence, and one which they are keen to lead and direct, with the other professions taking essentially supportive roles (Lupton, 1994). Those in health promotion are generally wary of such 'medicalisation' of health promotion, believing that doctors may have specific roles to play

within health promotion, but they are not well equipped to lead it (Werner, 1978).

The rise of evidence based medicine and critical thinking

As well as the barrage of criticism coming from outside, a critique of medicine, or at least a demand that it account for itself more overtly, has come from within medicine itself. The 'evidence based medicine' movement is based on the premise that for too long medicine has been based on untested, taken for granted practices, where different doctors are free to practice as they wish, without sufficient regard for the evidence on effectiveness (Cochrane, 1971). It is felt that this has resulted in an unjustifiably wide diversity of interventions, and thus very varied outcomes, across the country. 'Evidence based practice' then attempts to persuade doctors to base their activities on proper evidence (Sheldon *et al,* 1993).

The 'evidence based practice' movement is in line with a growing call for medical education to teach students to think critically as well as to learn facts. *'Tomorrow's Doctors'* (GMC, 1993) lists as its first '*knowledge objectives*': *'the discovery of how knowledge is acquired'; 'an understanding of research methods';* and *'an ability to evaluate evidence'*, while its preferred adjective to summarise the kind of practitioner it wants to develop is '*independent'*. In the GMC recommendations on medical education, the demand that medical education should foster '*critical study of principles and the development of independent thought',* has been reiterated in these reports for the last 40 years (GMC, 1957, 1967, 1980, 1993). A recent report of the Kings Fund, London, looked specifically into the teaching of the skills of '*critical thinking*' (Towle 1991).

The rise of evidence based practice and critical thinking are of relevance to health promotion in several ways. As we have seen, health promotion is generally keen to invite medicine to consider the limitations of its role and power, in order that it play an appropriate but not dominant role within health promotion. Furthermore, health promotion itself has been going through a similar process of being asked to account for itself. It too has had to become extremely conscious of the need to evaluate the effectiveness of its activities in an objective manner, and the emphasis is increasingly on evidence and accountability (Catford, 1983; Green and Kreuter, 1991; Tones and Tilford, 1994; Macdonald, Veen and Tones, 1996). Several large scale reviews of health promotion practice have put together meta-analyses of the evidence for the effectiveness of various health promotion interventions (Gatherer *et al,* 1979; Liedekerken, 1990; Veen, 1995).

So, in a variety of ways, the issue of the role and power of the medicine is of central interest to this research.

- ***This thesis will look at the extent and nature of teaching about the role and power of medicine, in relation to society, the other professions and patients, and staff***

attitudes towards this issue.

PATIENT CENTREDNESS AND COMMUNICATION

From voluntarism to patient centredness

We have seen that voluntarism, at least for the learner, is a key ethical principle in health promotion. Green and Kreuter (1991) see the principle of voluntarism as so essential that for them it forms part of their basic definition of health education: *'health education is any combination of learning experiences designed to facilitate voluntary actions conducive to health'*. They suggest that certain methods therefore need to be rejected on ethical and humanitarian grounds: these methods include manipulation, lies or distortion of the truth, or fear arousal. Such approaches are seen not as education but as 'indoctrination' (Snook, 1972; Campbell, 1990) and as not compatible with civilised or democratic values. Although empowerment approaches recognise the limitations of knowledge based education, and suggest that energetic educational techniques need to be employed to help people to become more autonomous, those who espouse them nevertheless tend to agree that participation in education for empowerment should be voluntary, at least for adults (Tones and Tilford, 1994).

Voluntarism is an essential ethical principle in medical practice too (Beauchamp and Childress, 1983), but what is meant by this terms in this context varies. In its most basic form it simply refers to the rights of the patient to refuse treatment. Many doctors operate with a passive concept of voluntarism, summarisable as: *'the treatment is there, take it or leave it, but don't expect medicine to take much interest in you if you leave it'*. They find it quite compatible with a top down, 'doctor centred' approach, which judges the effectiveness of interventions by criteria the doctor has predetermined, including the degree of 'compliance' the patient exhibits (Green, 1987; Ley, 1990).

There has for some time been a movement in medicine, lead by general practice, to turn the passive approach to voluntarism into the stronger concept of 'patient centredness', which puts the patient at the heart of health care (Armstrong, 1984; Pendleton *et al*, 1984; Levenstein *et al*, 1989). In 'patient centred' medicine, the patient has an active and participatory role, setting the goals and judging the outcomes (Brearley, 1990). Medical goals, such as the need for treatment are seen as needing to be balanced, or even subsumed, by others, such as the right of the individual to choose their own destiny, or to die with dignity (Beauchamp and Childress, 1983; Gillion, 1990). Patient centredness is seen as involving doctors in discovering, valuing and working with their patients' wants, needs, beliefs, feelings and opinions, and recognising the significance of their existing health and self-care practices (Tuckett *et al*, 1985).

Some of the impetus for the shift towards patient centredness has come from outside of medicine. There has been a change in public attitudes, partly facilitated by government action on behalf of patients (Secretaries of State for Health, 1989). The rise of consumerism and involvement in decision making has lead patients to be better informed, and no longer prepared blindly to trust professionals to look after their best interests (Haug and Lavin, 1983; Smith, Popay and Williams, 1994; Stacey, 1994). As the recipients of health care, many patients increasingly want to be central to the process and to make their own decisions on issues that affect them (McEwen, Martini and Wilkins, 1983; GMC, 1987b).

There has been movement towards patient centredness from within medicine too (McWhinney, 1989; Brearley, 1990). There is even evidence that in some cases, patient centred doctors are ahead of their patients, some of whom find it easier and more congenial to be passive (Wallace and Haines, 1984; Waterworth and Luker, 1990; Makoul, Arntson and Schofield, 1995), although on the whole patients prefer patient centred communication (Matthews, Sledge, and Lieberman, 1987; Ley, 1990). Doctors have contributed to research which has shown that a patient centred perspective can have very positive outcomes for patient health (Stewart, McWhinney and Buck, 1979; Roter, 1977; Bartett, Grayson and Barker, 1984; Kaplan, Greenfield and Ware, 1989). In terms of health promotion, it has been shown that patients are more likely to follow advice about preventing disease and promoting health if the doctor adopts a patient centred rather than a doctor-centred approach (Stott and Pill, 1990).

Policy documents have long emphasised the importance of patient centredness for medical education (GMC, 1987a). '*Tomorrow's Doctors*' suggests that students should learn *'compassion, and a concern for the dignity of the patient, and... the patient's family'* (GMC, 1993, p. 26). Medical schools have put some effort into teaching students to have greater empathy and respect for patients, and recent research suggests that students' patient centred skills and attitudes, which used to actually decline, now improve as their courses progress (Davis and Nicholaou, 1992; Meakin and Lloyd, 1996). This issue will be discussed in more detail in the section on communication that follows here.

However, patient centredness is still far from being the norm, according to Metcalfe, who claims that many in the medical establishment, especially in hospital medicine, have yet to accept a patient centred approach:

> *The concepts of person-centred medicine and patient power are relatively new. They owe their formulation within medicine almost entirely to general practice/family medicine; and without primarily to articulate patients and social scientists. These concepts are still, to some extent, unrecognised within the medical establishment.*
>
> Metcalfe (1989), p222

Patient centredness is then potentially a key area of overlap between health promotion and medical education, and there are clear links to be made between patient centredness and empowerment.

- ***This thesis will examine the extent and nature of teaching about patient centredness in the medical curriculum , and staff attitudes towards patient centredness.***

Communication

Self empowerment, social empowerment and patient centredness are inextricably linked with the nature and quality of the communication between client and facilitator or patient and doctor. The ideals of empowerment demand a particular range of communication skills, which are very different to those that have been used traditionally to 'tell people what to do' (Sankar, 1986; Demak and Becker, 1987; Burnard, 1989). They are basically the 'other-centred' skills, which put the patient and their needs at the centre of the process, and include the 'counselling' skills of listening, negotiating, reflecting back, clarifying, asking open questions and allowing silence (Nelson Jones, 1991; Corney, 1991).

However, such empowering skills would appear to be far from being universally possessed and practised by doctors. There has been a vast amount of research on the subject of communication between doctors and patients, most of it carried out in general practice settings. It has been summarised in a range of key texts, for example, in Pendleton and Hasler (eds) (1983) and Ley (1990), culminating in an international consensus statement, published in the world's international medical journals (Simpson *et al,* 1991). The consensus is that doctor patient communication has been both 'doctor centred' and ineffective (Pendleton *et al*, 1984; McWhinney, 1985; Schofield and Arntson, 1987). The overall picture is of rushed, highly focused encounters, in which doctors interrupt before patients have finished and then do almost all of the talking (Beckman and Frankel, 1984), fail to elicit at least half of patient concerns and complaints (Stewart, McWhinney and Buck, 1979), use incomprehensible language and mostly 'closed' questions (Simpson, 1980), and fail to explore patients' beliefs and concerns or to involve them in management plans (Byrne and Long, 1984). Through missing patients' 'cues', doctors sometimes fail to discover why the patient really came: they are particularly likely to miss the common psychiatric and psycho-social problems that are said to underlie the symptoms patients present in 50% of consultations (Freeling *et al,* 1985; Schulberg and Burns, 1988). Patients are said often to feel dissatisfied with such encounters, to the extent that most complaints about doctors are about communication rather than clinical competence (Richards, 1990). Patients tend to forget much of what they are told in them (Ley, 1990) or to imagine that topics have been discussed that were not (Makoul, Arntson and Schofield, 1995). The problem of lack of communication would appear to be particularly acute where the doctor

and patient come from different social classes, which do not share the same language codes or cultural assumptions (Bochner, 1983). Even in texts that claim to be concerned with conveying the principles of good communication, the authoritarian, and doctor centred term 'patient compliance' is usually still used to label the intended outcome, apparently with no sense of irony (Ley, 1990).

So, it would appear that the average doctor-patient encounter is not likely to be empowering for the patient.

Medicine itself is highly aware of these defects in doctor-patient communication, and doctors, especially general practitioners, have themselves been involved in a great deal of the research that has taken place, and has been cited above. Some practices and clinics have appointed a counsellor, or share one, and many doctors now routinely refer patients to this profession (Demak and Becker, 1987). Some however see this as 'passing the buck', and are keen to encourage doctors themselves to engage in the kind of counselling approaches which might result in patient empowerment (Pendleton *et al*, 1984; Cox, 1989; Schneller 1990; Balint *et al,* 1993; Makoul, Arntson and Schofield, 1995). It has been shown that doctors' anxiety that the resultant consultations would be too lengthy (Rowland, Irving and Maynard, 1989) appears to be unfounded, and that such consultations take no longer, when carried out by trained doctors (Stewart, Brown and Weston, 1989).

Some effort has been put into attempting to improve matters through both continuing and initial medical education. The Edinburgh declaration that followed the 1988 conference of the World Federation for Medical Education made clear the importance of communication skills for undergraduate medical education:

> *The individual patient should be able to expect a doctor trained as an attentive listener, a careful observer, a sensitive communicator and an effective clinician...*
>
> World Federation for Medical Education (1988)

More recently The GMC has suggested that patient centred communication skills are important to teach to '*Tomorrow's Doctors*', stating that, '*skill in communication is at the heart of counselling, ...an essential ingredient in the establishment of effective teamwork*' (GMC, 1993, p.17). The HEA's policy document on health promotion in the undergraduate medical curriculum takes pains to emphasise the need for doctors to communicate with patients about health *'in a manner that is supportive and non-directive*' (Pringle, Fragstein and Craig, 1997).

Most medical schools now have organised programmes of teaching on such patient centred communication skills, (Pendleton *et al*, 1984; Morris, 1988; Ley, 1990; Sanson-Fisher et al,

1991; Whitehouse, 1991). It would appear that such programmes are managing to reverse the tendency, noted in the 1970s and 80s, for students' person centred and communication skills to deteriorate through their medical course (Helfer, 1970; Helfer and Ealy, 1972; Scott and Donnelly, 1975; Ewan, 1988): more recent evidence would suggest that such skills now improve with time (Whitehouse, 1991; Davis and Nicholaou, 1992).

The specific features that make some communication skills courses for medical students more effective than others have been identified. It has been shown that closely defining the skills to be taught is beneficial, and many have put considerable effort into identifying the precise skills involved (Pendleton and Hasler, 1983; Stewart and Roter, 1989). A well structured approach, in which specific skills are practised in very small groups with a low student to teacher ratio, using role plays with standardised patients and feedback, and employing video tape, has been shown to be the most effective approach (Caroll and Munroe, 1979; Bouhuijs, 1987; Schofield and Arntson, 1989) and is now used in many medical schools (Morris, 1988; Jones et al, 1989). It would appear particularly crucial to the success of this approach that the staff who do the teaching are trained to run these courses in a systematic way (Gask, Goldberg and Boardman, 1991).

It would appear then that patient centred communication is essential if the doctor-patient encounter is to be 'empowering' for the patient, and the teaching of such skills is therefore of key interest to this thesis.

- ***This thesis will attempt to assess the extent and nature of teaching about communication in the medical curriculum and staff attitudes towards this issue.***

MEDICAL STUDENTS' OWN HEALTH

The health status of doctors

The health of doctors is a vital factor in influencing how effective they are likely to be in promoting health. Doctors are more likely to have positive attitudes towards health promotion for patients if they are healthy themselves, while patients find health promoting messages more credible if they come from healthy doctors (Campbell *et al*, 1985).

However doctors are notoriously bad at looking after themselves, and there have been many calls for doctors to do more to take care of their own health (Payne and Firth-Cozens (eds) 1988; Burnard, 1991). Doctors have a much higher morbidity rate than is commensurate with their social class (Richards, 1989) and are especially at risk from cirrhosis, accidents, and poisoning (Allibone, Oakes, and Shannon, 1981). Little has been written about UK doctors attitudes and practices in relation to their own physical health, outside of a few

research papers on exercise (Campbell *et al*, 1985; Chambers and Bowen, 1985). However, much has been written on their mental health: doctors are said to be particularly prone to stress related problems (Richards, 1989; BMA, 1992) such as burnout (Parker, 1990), alcohol abuse (Murray, 1976; Lewy, 1986) and suicide (Firth-Cozens, 1987; BMA, 1992, 1993).

The iatrogenic medical school?

There is strong evidence that medical education itself is positively bad for health. In both the UK and the US medical education has traditionally been seen as an initiation process as well as an educational endeavour, in which those of the 'right stuff' have to survive the stress, the long hours, the emotional challenges of dealing with the sick and the dying without the need for help or support: those who cannot cope are advised to find other occupations (Coombs, 1986; Firth, 1986). In the US, research has uncovered an alarming picture of what is termed there 'abuse' of medical students (Meli, 1990; Silver and Glicken, 1990; Bourgeois *et al*, 1993), for example by routinised bullying, intimidation embarrassment (Hardison, 1986; Wolf *et al*, 1991) and sexual harassment by staff (Wolf *et al*, ibid), which most students found very upsetting, and which had a highly detrimental effect on their morale and levels of cynicism.

Reducing the stress of medical education

Acceptance of this state of affairs is now beginning to be questioned. The American Medical Students Association 1992 conference had as its theme '*Medical Training: a Matter of Survival?*', while in the UK the need for doctors to have a 'stiff upper lip' has been called in doubt even in such august journals as the British Medical Journal (Lask, 1987). A few years ago an edition of '*Medical Education*' (volume 28, 1994) was entirely devoted to the issue of student well being, and included a UK paper entitled '*Need medical education be stressful?*' (Deary, 1994).

Many have written about medical students' stress (Firth, 1986; Linn and Zepper, 1986; Lloyd and Garrell, 1983) anxieties (Tooth, Tong and McManus, 1983; Moss and McManus, 1993), and alcohol consumption (Collier and Beales, 1989). Research that has identified medical students with particular learning difficulties has shown that such difficulties lead to high levels of stress (Ryde, Wallace and Bidgood, 1993; Coles 1994).

However a survey by Coles (1993) of the Deans of medical schools in the UK gave some limited grounds for optimism: it showed that in most schools students were receiving support in the form of a personal tutor and career advice, just over half provided formal study skills teaching, and one third offered formal teaching on the management of stress (Michie and Sandhus, 1994).

Impaired physicians?

Some writers see these stress related health problems as not so easily tackled. They believe that the problem has deep roots, being symptomatic of a fundamental problem that goes to the heart of the image doctors have of their role as 'dispassionate professional', an attitude which leads doctors to deny their own emotions and become 'impaired physicians' as a result (Scheiber and Doyle, 1983; Smith, Denny and Witzke, 1986; Coombs, 1986, 1991). Coombs (1986, 1991) has written eloquently of what he sees as the denial of emotion in medical education and the coping mechanism of 'disembodied intelligence' doctors assume. He argues for a more balanced emphasis, which allows the routinised expression of subjectivity and feeling, so that the 'crisis intervention' that he sees as characterising the approach to mental health in medical schools can be avoided. Others too perceive the damaging 'desensitisation' of medical students as needing to be tackled by actively helping students to process their own emotions, reactions and needs (Hull, 1991; Charlton, 1993). Personal responses to death and care of the dying are thought to pose particular challenges for inexperienced medical students (Sykes, 1989), and those from both general practice and the palliative care movement have written with concern of what they see as the neglect of this issue (Hull, 1991; Field, 1984).

The physical health of students, and the 'settings' approach

To date, most of the focus in the UK on the health of the medical profession and medical students has been on their mental health. In the US there are elements of a wider concern, which includes both students' physical health and the context in which they learn. Medical schools there claim to take a rather more positive approach and include holistic programmes on health promotion for medical students (Goldsmith *et al*, 1980; Levy 1984; Patterson *et al*, 1990; Wolf, Randall and Faucett, 1990b; Wellness Perspectives, 1991) and some are even looking more widely at the overall services, organisation and policies of the medical school and their impact on student health in general (Pasnau and Stoessel, 1994; Hall and Miller, 1994), which, in health promotion terminology, could be termed a 'settings' approach.

The degree of concern shown for the students' own health would appear to be an important indicator of the importance attached to health promotion in the curriculum, and is therefore of strong interest to this research.

- ***This thesis will examine the extent and nature of teaching about, and/or a concern for, students' own health in the Medical School, and at staff attitudes towards this issue.***

PRIMARY CARE AND THE COMMUNITY

From hospital medicine to Primary Care

For some time, acute, high technology and hospital based services have been criticised for taking the major share of the health care budget in most countries (WHO, 1978). Many feel that hospital based medicine needs to be balanced by adequate spending on the low technology, community based services that could help those increasingly large but mainly uncomplaining groups that most need care, such as older people, the mentally ill and the chronically sick (DoH, 1987). In many countries health budgets are seen as spiralling out of control. As resources are never infinite, it has been pointed out that it is vital that health spending be organised rationally and fairly, according to the real needs of the population (Canadian Public Health Association, 1990). The WHO's 'Alma Ata Declaration' (WHO, 1978) stated that primary health care and community care should become the focus of the medical system, with secondary and tertiary services playing a supportive role. Such calls are now being taken seriously at government level, where the direction of policy for many years has been that Primary Care to play the lead role within the NHS (DoH, 1987, 1992, 1997).

There has been a complementary demand for a reorientation towards Primary Care and the community in medical education (Walton, 1985a, 1985b; Metcalfe, 1984; Tudor Hart, 1986), for example at the World Summit for Medical Education (Walton, 1993; Mogedal, 1993). A UK survey by Lefford *et al* (1994) and a review article by Habbick and Leeder (1996) suggested that many medical schools are starting to shift more of their medical education into the community, although Hamad (1991) has pointed out the elusiveness of the term 'community', and the need to define it carefully.

Primary care and health promotion

The move towards Primary Care and the community is connected with the interests of health promotion in several ways. Primary Medical Care is in many ways seen as a key discipline in the transmission of health promotion in medical education, because it appears to be the specialty in which students are more likely than anywhere else to learn about the community, about social empowerment, and about the patient centred and holistic attitudes that are so key to the transmission of health promotion (WHO, 1984b; Mattson *et al*, 1991). The move also echoes recurrent concerns in health promotion about the need for equity, and the fair distribution of resources to those who need them (WHO 1986b; Nussel, 1990). By providing experience in the community, Primary Care could help medical students lose some of their individualistic focus and gain a more social perspective (Kisil and Chaves, 1994). The WHO (1987b) make that link plain when they define community oriented medical education as '*medical education which is focused on population groups and individual persons in the community, which takes into account the health needs of the*

community concerned.'

Some medical schools have attempted to locate their teaching of health promotion in the community, with some success (Joffe and Farrant 1987, 1989; Gillies and Elwood 1989). The World Summit for Medical Education (Mogedal, 1993) presented evidence for the effectiveness of teaching medical students using community network approaches to health promotion in Primary Care (Dowell and Gosling, 1993).

- ***This thesis will examine whether there has been a shift to teaching more about Primary Care and the community in the medical curriculum, and, if so, what staff thought about this development.***

TEACHING, LEARNING AND ASSESSMENT

The importance of the 'hidden curriculum'

So far in this chapter we have looked at the curriculum in terms of a series of topics and issues that relate to health promotion. However the transmission of these issues is by no means a matter of curriculum content alone. One cornerstone of the most highly regarded work in health education is the recognition of the importance of the way in which the curriculum is transmitted, what has been termed in both health education (Young, 1992) and medical education (Snyder, 1973) 'the hidden curriculum'. 'The hidden curriculum' refers to deeper processes which underlie the taught curriculum, such as assumptions made about the nature of knowledge and the educational task, the relationship between the teacher and the taught, methods of teaching and learning, and the nature of assessment. As Coles (1985b, 1987, 1990) and others (Genn and Harden, 1986) have argued, it is the context of the entire curriculum that affects students' perceptions and approaches to learning including their assessment of the value of what is taught. So issues that relate to health promotion should not be looked at in isolation, but as to some extent embedded in teaching about a range of wider issues and processes.

The importance of process in medical education research

In investigating curriculum processes in the case of this research it is likely that there will be much to find. Curriculum process has been of profound interest to medical educators for many years now, and calls for change are now being made by the medical establishment. For example, in a recent report by the Kings' Fund (Towle, 1991) on *'Critical thinking: the future of medical education'*, 7 of the 11 principles listed as *'needed to inform the curriculum of the future'* were concerned with process. They included for example, *'reduction in factual information; active learning (enquiring doctor); core knowledge,*

skills, attitude; methods of learning/teaching and assessment to support aims of the curriculum' (*ibid*, p. i). Indeed the concern with process has dominated to such an extent that some have suggested that the pendulum has swung too far, and have called for a return to a greater concern with content (Voratsky, 1986).

So we look at these wider, more process related issues as, although they may not themselves have been overtly or consciously connected by respondents with the teaching of health promotion, they should be viewed as essential foundations to the development of any work on it.

- ***This thesis will examine the attitudes and practices of the medical staff towards teaching and learning and assessment.***

Educational epistemologies

We have already seen when we looked at models of health education and health promotion, that particular epistemological assumptions about the nature of education underlie the different approaches. The rational educational approach takes a predominantly cognitive approach, the behaviour change approach is concerned with behaviour and skills, while the empowerment approach looks at both these issues, but adds the domain of attitudes and emotions. So the extent to which the medical curriculum itself attempted to transmit knowledge, behaviour or attitudes and the balance between these domains, is likely to affect the models of health education and health promotion to which students respond and which they go on to use in their eventual practice.

In any case, educational theory has for some time been pressing the concept of education as more than knowledge. The competency based movement has developed a useful tripartite model of education as involving knowledge, attitudes and skills (McGaghie *et al*, 1978). Others have emphasised a view of education as the learning of processes (Entwistle and Ramsden, 1983; Gagne, 1984) and the acquisition of the ability to reflect (Schon, 1983). Congruent with these developments, medical education has to a great extent come to recognise the importance of the need to clarify what key attitudes and skills are needed for the effective medical practice, and teach them with the same commitment as they have traditionally devoted to teaching facts (Jayawickramarajah 1986 and 1987; Towle, 1991). All recent curriculum policy documents, and in particular '*Tomorrow's Doctors*' (GMC, 1993) make much of the need to reduce the burden of factual information, to assess more than recall, and to identify, teach and assess deeper skills and wider attitudes.

Approaches to learning

A particular issue that has proved to be of great interest to medical educators, and on which a considerable amount of research has taken place, is medical students' approaches to their

learning. To simplify a highly complex issue, a contrast has emerged between approaches which involve students staying on the surface, and seeing their task as the memorisation of facts which they then regurgitate in examinations, and approaches which encourage students to engage in 'deeper processing', making sense of what they are learning, seeing the underlying links between issues and grasping the principles involved, an approach which Coles has termed 'elaboration' (Coles, 1989).

Some have claimed that the 'problem based' approaches to medical education which are popular in some parts of North America and in the Netherlands encourage such deeper processing (Barrows and Tamblyn, 1980; Pallie and Carr, 1987). Evidence for significant long term differences in the cognitive abilities of students taught within traditional or problem based approaches is equivocal. However it is clear that problem based curricula provide a more enjoyable experience for the students, which they find more nurturing. They also have clear benefits for improvement in faculty attitude, class attendance, and measures of humanism (Vernon and Blake, 1993; Albanese and Mitchell, 1993). So it would appear that problem based approaches are more likely to encourage attitudes and practices that are linked with health promotion and student self empowerment.

There is clearly then a fundamental link to be made between this extensive work on approaches to learning and self empowerment in health promotion. It could be conceptualised that the empiricist, 'knowledge/facts' based approach to learning is essentially depowering, putting the learner in a passive relationship to the world, while a 'process/ skills/ understanding' model of education can be seen as empowering, as it places the learner in an active, central role.

- ***This thesis will examine educational epistemologies, including the relative roles played by knowledge, attitudes and skills in the medical curriculum***

Methods of teaching and learning

If education is about attitudes and skills, including those that lead to the ability to reflect on practice, to engage in deeper processing, and to solve problems, then effective education demands a wider range of methods than the lectures and reading that have conventionally been used to help learners acquire facts. To acquire such skills and attitudes, students need to engage actively with the task and make it their own in an active way (Bligh, 1980). Within education as a whole the emphasis has for some time been less on passive tasks and as much as possible in participatory and active learning (Kolb, 1984). Medical education too has been engaged in attempts to break free from the shackles of the lecture based curriculum, and engage students in a wider range of more participatory approaches (Towle, 1991).

Such efforts to develop more active approaches link directly with the notion of self empowerment. We have already noted the central importance to the empowerment model of health promotion of active and participatory methods of teaching and learning. Health education can be said to have been at the forefront in developing a wealth of strategies for accentuating the positive and involving people in their learning, making use of a very wide range of methods to be used in both one to one and group situations (Satow and Evans, 1982; Brandes and Ginnis, 1986).

- ***This thesis will examine the methods of teaching and learning employed in the medical curriculum.***

Student centredness

A cornerstone of the self empowerment approach to education is the centrality of the learner to the process, and the need to engage in activities that build the learner's sense of self worth and efficacity. There has been some considerable work on the role of self esteem in the promotion of effective learning (Coopersmith, 1967; Aspey and Roebuck, 1977). Educational theorists have long recognised that too, to be effective, the educational task must be right for the learner and 'start where they are', cognitively and affectively (Piaget and Inhelder, 1958; Gagne, 1964 and 1984; Maslow, 1971; Weare, 1992).

Within medical education the drive for 'patient centredness' which this chapter has discussed in some detail has been matched by a concern that medical education be 'student centred'. Carl Rogers (1983) has been a highly influential figure in both movements, with his insights into the central role of the relationship between teacher and taught as a key determinant of the quality of learning. Again, '*Tomorrow's Doctors*' (GMC) makes much of the need to encourage a 'student centred' approach, which it sees as involving a greater degree of self directed learning, flexibility, optional activity and student feedback in an erstwhile fixed curriculum.

- ***This thesis will examine attitudes towards student centredness, and attempts to make the curriculum more student centred.***

Assessment

At a basic level, it will be of interest to discover whether and to what extent issues and topics that this chapter has identified as key for health promotion are covered in the student assessments and examinations.

However, assessment is connected with health promotion in more indirect ways too. Along with methods of teaching and learning, methods of assessment are also a vital part of the 'hidden curriculum' that have an impact on how students experience their course, and thus

on a range of attitudes relevant to health promotion. There has been some considerable research in medical education on the influence of assessment on student learning. It appears that students' perception of the nature of the assessment has a significant influence on the learning strategies they adopt (Laurillard 1979; Marton and Salgjo 1976). Assessments which require simple recall of facts tend to influence students to engage in rote learning (Dahlgern, 1978) while those which require deeper levels of understanding encourage students to attempt to understand the deeper processes and connections that underlie the surface (Coles, 1989). Students become very confused if there is a mismatch between what they are required to do on the taught part of the course and what is demanded of them in their assessment (Snyder, 1973). It is therefore of great importance that medical schools match their intentions with the nature of their assessments (Coles, 1987; Towle, 1991), but there is evidence that there is often a mismatch between the two (Lowry, 1993).

We have seen that educational research and theory suggests that, if they are to empower their future clients, students need to feel powerful themselves. As with their learning in general, students need to experience their own assessment as positive and sensitive to their needs, so that they learn to behave in a positive and sensitive way to their patients and colleagues. As we have already indicated, there has been considerable work in medical education, particularly in connection with the teaching of communication skills, on finding ways of assessing students which enhance their feelings of self-esteem and motivation, and use constructive feedback to impart a positive sense of what students do well, and clear advice about how they can improve (Pendleton *et al*, 1984; Morris, 1988; Ley, 1990; Sanson-Fisher et al, 1991; Whitehouse, 1991).

- ***This thesis will examines practices and attitudes towards the assessment of students in the medical curriculum.***

The importance of teaching in the medical school

Fundamental to a great many issues that have been looked at in this rationale chapter is the importance of teaching in the minds of staff and in the Medical School as a whole. It will affect, for example, how significant students perceive themselves to be in the total scheme of things. It will influence the likelihood of staff engaging seriously in the kinds of educational changes that will be needed to respond to demands on them to teach more and better (Towle, 1991), including demands to improve the teaching of health promotion and the issues that relate to it (Gillies and Elwood, 1989; Weare, 1990b; Amos, 1991).

- ***This thesis will examine the importance of teaching in the Medical School.***

CHAPTER TWO

METHODOLOGY

Methodologies employed in previous studies

Such previous studies of health promotion in undergraduate medical education as exist in Britain, Europe and the United States, have often simply been descriptions of individual programmes (Weare, 1988b and 1990a; Gillies and Elwood 1989; Amos *et al* 1991) or overviews of programme descriptions (Whitehead, 1990). Such research as exists into curriculum coverage and staff attitudes has mostly used standardised postal type questionnaires (Metnecki and Voros, 1972; Bartlett, 1984; Jonas 1988; Randall, 1989; Crimlisk 1990; Meakin and Lloyd 1996) usually sent to the Dean of the medical school in question.

The advantages of the postal type, self completion questionnaires in terms of low cost, mass coverage and avoidance of interviewer bias are well known, however, so are their many disadvantages (Oppenheim, 1992). They have a notoriously low response rate, and therefore potential sample bias. There is no control over the order in which questions are answered, or on the passing on of questionnaires, and no check on incomplete responses. Most serious of all in the context of this issue in particular are the semantic difficulties they can pose, offering no opportunity to clarify terms, correct misunderstandings, or to probe. Given that *'health promotion'* and *'health education'* mean such different things to different people and professions (Sutherland, 1979; Collins, 1984) there is no way of knowing whether the respondent is interpreting questions which used these terms in the way that the researcher intended. The rationale chapter suggested that the medical profession tend to have rather restricted and negative interpretations of these terms (Boulton and Williams, 1986; Weare, 1986, 1988a; Redfern, 1994), tending to identify them with prevention, and with top down, imposed interventions, in comparison with the wider and more positive agendas that tend to be employed by those in health promotion. However, if the questionnaire employs such a wider agenda, and asks about a range of issues that relate to health promotion in the mind of the researcher, we have no way of knowing whether the respondent sees them as such. In any case, any such issues, such as 'patient centredness' or 'holism' are themselves likely to be semantic minefields too.

It seems likely that such difficulties will have beset the attempts at questionnaire surveys attempted to date. However, it is hard to know exactly as most of the research cited has been written for publication in article form, in which methodological details tend to be somewhat cryptic. However, one survey which was written up as a fairly lengthy report and

thus provides fairly full details is that of Randall (1989), called *'Health Promotion in the Medical Undergraduate Curriculum'* undertaken on behalf of the HEA. It will be looked at in some detail here as it illustrates many of the difficulties inherent in such approaches in general, and particularly in the context of health promotion in medical education.

The questionnaire was sent to all English medical schools, then 22 in number. The author of the report claims a 59% response rate, but this is highly misleading. As the report also makes clear, 11 of the medical schools had sent members of staff to a recent HEA workshop: for these 11 schools, the questionnaire was sent to the 'known contact' who had attended the workshop. Responses were received back from 7 such schools, all fully completed. For the other 11, with no known contact, the questionnaire was sent to the Dean. 6 of these schools sent back questionnaires, but two of these had completed none of the replies, instead, according to the author of the report, *'adding comments which showed either a lack of understanding of, or a lack of sympathy for health promotion'* (*ibid*, p.19) For example, one wrote *'I don't know what health promotion really is? Preventive medicine? Diet? Screening?'* (*ibid,* p.19). So, of the 11 schools, half of the sample, in which there was no known and interested person to write to and the Dean was contacted (which as we have seen is the method most usually used in sending out such questionnaires) only 4 made any useful reply, a response rate of only 27.5%. Given that the questionnaire came from the major national body, one wonders what response rate is achieved in similar questionnaire surveys that come from establishments which may have even less 'clout' with medical schools, such as other Universities.

Given then that 7 of the 11 actual respondents had recently shown themselves to be interested enough in health promotion to attend a three day workshop on the subject, the issues of selection bias must be raised. It is surely apparent, for example, in the responses to the initial question *'do you think health promotion is important for all doctors/ some doctors/ very few doctors/ no doctors?'*, for which the author notes that *'the majority of respondents considered health promotion important for all doctors'*. As the author herself notes in her analysis of responses to another question *'with 50% of this sample* (in fact more, as we have pointed out) *already actively involved in health promotion the result is probably skewed and therefore not reliable'*. One wonders too what effect receiving the questionnaire from the very body who had paid for their attendance at the workshop had on the degree of 'prestige bias' of respondents' replies.

The questionnaire took a broad and generalist approach, and explicitly attempted not to 'lead' responses by defining what was meant by health promotion. For example, questions included *'what skills and attributes are important if doctors are to promote health?'* On the positive side, the result was some interesting agendas, and useful insights into the understandings of medical staff as to what they meant by health promotion. For example,

respondents nominated communication skills, such as teaching skills, information skills, advocacy, and empathy *'three times as frequently as any other issue mentioned'* in answer to this particular question. However, quite aside from the again obvious issue of sample bias, as the author comments, there is no way of knowing, if a particular domain is not mentioned in an answer, whether the respondent really did not think it important or just that they did not connect it with health promotion. For example, respondents were said to have *'failed to identify personal health promoting activities'* in their response to the above question on skills and attributes. The author herself points out the problem of scope and definition: *'health promotion is an area without clearly agreed criteria and definitions and consequently lacks, as yet, scientific precision'* (ibid, p. 19). .

So it would appear to be vital, when issues are as confused, complex and unmapped as is health promotion in medical education, to use more qualitative approaches. However, to the author's knowledge, apart from an interview survey by Redfern of 8 professors of General Practice (Redfern, 1994) she is the only person to have attempted to use face to face interviews in an attempt to look at the treatment of health promotion and staff attitudes towards it in the undergraduate medical curriculum, in a small scale survey she undertook in the mid 1980s (Weare, 1986 and 1988b). This survey managed to question all the staff who coordinated the various courses that made up the medical curriculum, so there was no selection bias, at least in term of specialty or likely interest in health promotion. The open ended questions used appeared to be able to 'start where staff are' by initially asking some general questions about the course in question, from which the presence or absence of health promotion issues and processes could be deduced. It was also possible to ask staff about their perceptions of 'health promotion' and also to ask a range of questions around issues that the author felt were relevant to health promotion even if the respondent did not. Difficulties or misunderstandings could be easily dealt with at the time of the interview. The satisfaction achieved from carrying out this piece of work lead to the research under discussion here, although the former was 'quick and dirty' in comparison with this current effort.

THE NATURE OF THIS ENQUIRY

Qualitative approach

As the issue to be investigated, the relationship of medical education to health promotion, is then relatively uncharted waters, it was decided to use an approach which was qualitative, and which could attempt to 'map' the territory, describe concepts and ideas, identify characteristics, understand meanings and suggest relationships, rather than a quantitative approach which would attempt to measure predefined variables in a precise way.

The term 'qualitative' tends to be used as the parent title for a whole family of approaches, of which the most prominent, and useful are 'ethnography' (Hammersley and Atkinson, 1995),'interactionism' (Blumer, 1969; Rock, 1973) and 'phenomenology' (Schutz, 1964; Giorgi, 1986). All the members of the family differ from one another in ways which are interesting, but the discussion of which would be an unnecessary digression. This research will take its tone from many of the key modern texts on research methods (Strauss and Corbin, 1990; Bryman and Burgess, 1994; Miles and Huberman, 1994) and stick to the use of the simple, overarching term 'qualitative', while recognising that such a label incorporates a multitude of slightly different perspectives.

The 'qualitative' approach sees the social world as a construct, put together actively by those involved (Berger and Luckmann, 1967). In understanding social life, the meanings of participants are of key importance. Such an approach does not claim that there are no regularities and patterns to human behaviour, but it tries to get to them in a 'bottom up' way by starting with specific examples of events and identifying commonalities by inference (Miles and Huberman, 1994). Data are collected in as 'natural' a context as possible, examined for patterns, descriptions and relationships, to identify variables and generate theory, and written up in a way that stays as close to the original data as possible (Hammersley and Atkinson, 1995; Burgess, 1984). It is an emerging and inductive process (Bryman and Burgess, 1994).

The overlap of qualitative and quantitative approaches

Although, partly to help overcome the defects of previous research in this area, this research is qualitative, this is not to dispute the value of quantitative approaches. The antagonism that characterised the attitude of those on both 'sides' of the qualitative/ quantitative debate through the 1960s to the 1980s (Blumer, 1969; Giddens, 1979; Smith and Heshusius, 1986) is now gradually abating, and the two approaches are increasingly being seen as compatible and complementary (Howe, 1988; Miles and Hubermann, 1994; Hammersley and Atkinson, 1995), especially in applied contexts, such as health (Burnard and Morrison, 1990; McDonald and Daly, 1992.)

One feature that both approaches share is the need to acknowledge the scope and boundaries of the investigation. Some of those who write about qualitative research give the impression that research can start from a completely open minded position and derive all its theory from the data itself. But this is disingenuous. All research, including the most 'grounded' theory (Glaser and Strauss, 1967; Strauss and Corbin, 1990) is to some extent shaped by previous research and literature, is based on prior assumptions, and has parameters that define what is within and what is outside the scope of its investigation (Miles and Huberman, 1994). Without such definitions any investigation would be impossible: there can be no such thing as completely naive research. The question of how

fixed or open, structured or unstructured, qualitative or quantitative, positivist or interpretivist a piece of research is, is not a matter of absolutes, it is a matter of degree. What is important is to be clear to the reader what the given structure and prior assumptions of the research are, rather than pretend not to have them.

This research was based on some known starting points, which provided some basic structure and some boundaries. The rationale chapter has already indicated that this research was predicated on a clear aim, to explore the relationship between health promotion and medical education. So, from the outset, the intention was to analyse the data through the 'filter' of a health promotion perspective. A set of research objectives were arrived at through a process of logical analysis of the literature, and shaped, inevitably, by the prior experience of the author, who had been involved in health promotion in general for twenty years, and conceptualising and researching health promotion in medical education, in the context of this Medical School in particular, for over a decade. These objectives then defined the scope of the investigation, shaped the questions that were asked in the interviews and provided a starting point for the construction of a framework for the analysis of the interview and written data. The intention was to use these objectives as starting points for questions, but to allow the data both to provide unexpected answers to the questions, and redefine the questions themselves.

Rationale for using interviews, and for looking at the staff of only one medical school
This research is based on a series of interviews with staff from the Medical School at Southampton, and on analysis of the medical curriculum book staff produced.

This research is very much looking at what staff thought they were doing, and their attitudes towards what they were and were not teaching, rather than at the curriculum as the students experienced it, the 'curriculum on paper' rather than 'the curriculum in action' as Coles and Gale (1985) put it. The reason is that staff and their attitudes are the most significant determinants of the curriculum, and so understanding and proposals for change need to be grounded there.

However it should be borne in mind when reading this thesis that the information about the medical curriculum comes from what staff said in interviews and what they wrote in the medical curriculum book. So where the objectives for the study talk of uncovering aspects of 'the medical curriculum' it means the medical curriculum seen through staff eyes, as the text will attempt to make clear.

It was decided to take one medical school only, and attempt to do some fairly deep and exploratory interviews there, rather than to spread the enquiry over several schools, for a variety of reasons.

The main reason was the basic assumption of this research, that there is a major problem of definition when looking at health promotion in medical schools. This problem of definition means that trying to undertake a meaningful questionnaire survey, or series of highly structured interviews, in this field is currently a impossible task. Few in medical education understand what meant by health promotion, and vice versa. The few surveys of health promotion across several medical schools that have taken place have come up with very negative findings (Metnecki and Voros, 1972; Sharp, 1990). This may well be because the health promotion staff who wrote the questionnaires had an incomplete picture of possible areas of interest in the medical curriculum, and/or because those in the medical schools who responded to the questions had an incomplete understanding of what is involved in health promotion.

The aim of this research is to explore the relationship between medical education and health promotion by looking for the underlying content and principles that are relevant to health promotion in areas taught right across the medical curriculum, regardless of whether or not medical staff thought of what they taught as 'health promotion'. Given the problems of definition, it therefore seemed essential to use some fairly open ended, exploratory and probing interviews, as only this technique is sufficiently interactive to ascertain which terms are meaningful to which respondent, and explore respondents' underlying meanings (Brenner, 1985; Powney and Watts, 1987; McCraken, 1988; Breakwell, 1990).

The author was also keen to look right across the curriculum. Often interest in health promotion is restricted to those parts of the curriculum most likely to teach it, in particular Public Health Medicine, the psycho-social sciences, and Primary Care. Although interested in the place of health promotion in these specialties, this research also sought to discover whether, and how, the total curriculum contributed to or undermined a health promoting perspective. So, the need for breadth, coupled with the previously mentioned need for depth, dictated that only one institution could be looked at.

The intention is that this research will contribute to our basic understanding of where the 'two worlds' might overlap, and be a useful agenda setting exercise for those who would develop health promotion in medical education to help them develop more appropriate strategies. It is not intended that this research will constitute the definitive answer to the kind of detailed questions that those who are working to develop health promotion in the context of other medical schools, or nationally, may have, but it may at least make their questions more informed and wide ranging.

There are however grounds for believing that the findings of this research have some generalisability to a wider group than the individuals studied in this one setting. As we have said, the focus of the research was not directly on this particular curriculum, but the medical

teachers that taught it, and their underlying intentions, attitudes and assumptions which shaped the curriculum. It is reasonable to assume these teachers will have had a range of experience of other contexts, including attending other medical schools as students and teachers. (In fact, of the 46 interviewed, only two said that they had been Southampton students.) So, although there is no claim being made that they constituted a representative sample of medical teachers in the UK, it is likely that their views may be not completely unlike those of medical teachers in other medical schools, because their educational and professional backgrounds will be similar.

The extent to which these finding are generalisable will be influenced to some degree by the extent to which the Southampton Medical School is similar to others. To enable the reader to assess this, the next section will provide an outline of how the course was put together, and the roles played by those who were interviewed. This account will also give the necessary background for an understanding of the findings that follow, which will very much be structured around the courses and attachment that made up the medical undergraduate programme.

THE CONTEXT OF THE RESEARCH

The Medical School

Southampton Medical School is in medical school terms relatively new: *'only the second to come into existence in the United Kingdom since 1893'* according to the medical curriculum book (University of Southampton Medical School, 1996, foreword). It took its first intake of 40 students in 1971. At that time it saw itself as highly innovative seeing as its distinctive approach:

> *early patient contact, the integrated systems-based approach, experience in general practice, the fourth year study in depth and the final year of clinical apprenticeship throughout the Wessex Region'*
>
> (*ibid,* foreword)

All of these features were still in operation at the time the research was carried out, although it was generally agreed across the Medical School that they were no longer particularly innovative, and had now become fairly standard across UK medical schools. This gives further cause to believe that a case study of this one medical school may give rise to findings that are of wider interest.

Southampton prided itself on having a *'system based integrated course'* (*ibid*, preface). The course was organised into the traditional preclinical/ clinical phases, where the study of the basic sciences for the first two years was followed thereafter by clinical practice. However

particular efforts had been made to blur the boundaries:

> *the basic structure of "overlapping wedges" proceeds from a phase which is predominantly science based, but incorporates early patient contact and teaching about clinical disorders, to a third year spent mainly in clinical departments but accompanied by regular reference to the preceding years' programme...'*
>
> *ibid*, p.1

The structure of the curriculum and names of courses are shown in table M1, which is taken directly from the Medical Curriculum booklet. (This diagram was universally used across the medical school, for example in course materials and in the course information on the Internet.)

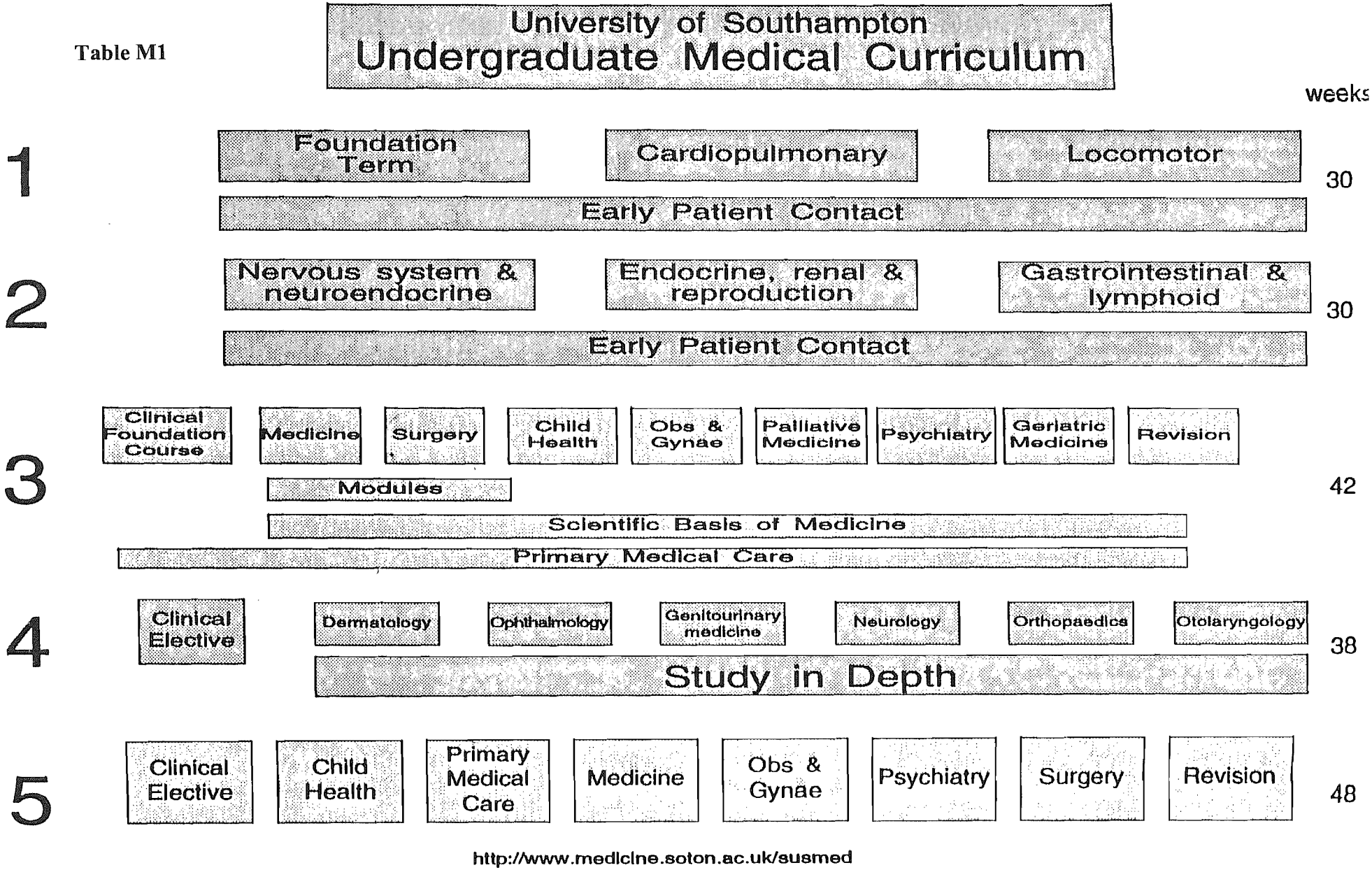
At the time at which the main data for this study were collected (1995/6) the intake of students was about 160 a year, a number which had recently increased from the 130, which had been the intake since 1976.

The first two years were concerned mainly with learning the sciences thought basic to medicine. They began with a **Foundation Term,** which '*is intended to provide a period of time when the students can adjust to University life...*(it) *aims to provide a perspective for medicine as a whole.*' (*ibid*, p.7). It was followed for the next five terms by **Systems Courses**, which each took in turn one system of the body and explored it in detail. The basic sciences of anatomy, human morphology, physiology, biochemistry, pharmacology, and pathology, together with the psycho-social sciences of Psychology and Sociology, and Public Health Medicine were taught under this 'systems' heading. Students followed each course in turn, as a whole group. The bulk of their contact time was spent as a whole group in lectures and divided into two groups for practicals, but they attended one or two tutorials in groups of 20 or so in various parts of the course.

At the time of the interviews, each term had a **psycho-social and public health medicine theme**, which attempted to link Psychology, Sociology and Public Health Medicine, and the lectures picked up on topics of relevance to that particular theme. However how this teaching was organised had varied greatly over the previous few years, and staff were in the process of disentangling their subjects and teaching them separately from one another, a process the Teaching Quality Assurance coordinator described as *'debadging'*. This process of disengagement will be looked at in more detail in the findings chapter.

In addition, in order to provide some clinical contact with patients, students spent a few days in the first year on **Early Patient Contact**, in Primary Medical Care and in Human Reproduction, going on visits in small groups to patients' homes and to the delivery suite in the hospital department of Obstetrics.

Table M1



http://www.medicine.soton.ac.uk/susmed

The third year opened with the 6 week **Clinical Foundation Course** which attempted to provide an overall generic introduction to clinical work. Students were attached in groups of 3 to a clinical tutor, who could come from any speciality, and who was *'responsible for their introduction to communication skills, clinical history taking and clinical examination'* according to the course handbook. Students then spent most of the year on 8 **Clinical Attachments**, most of which were 3/4 weeks long, however Surgery and Medicine covered 8 weeks and Palliative Care only one. Students rotated around 7 of these attachments in groups of 25 or so. One attachment, Primary Medical Care, followed a very different pattern, with 23 half day sessions throughout the year spent with GPs in the community and 7 half day seminars conducted at the Medical School. In addition the **Scientific Basis of Medicine** course ran for one afternoon a week throughout the year; it was attempting *'to integrate the basic scientific knowledge acquired in the first two years into a clinical context', (ibid*, p.31). The Intermediate Examination, which formally tested the learning of the first two years as well as that of the third year, took place at the end of the third year. The intention of leaving the examination to this point was again an integrative one, the idea being that students would by then have started better to appreciate the relevance of the basic sciences to clinical work.

The fourth year began with an 8 week **Clinical Elective** *'in which students may choose to study any aspect of clinical medicine, anywhere in the world' (ibid*, p.49). The students then spent the bulk of the year on the **'Study in Depth'**, *'a project of his or her choice which may be in almost any area of relevance to medical practice' (ibid*, p.51). They also spent the equivalent of 8 weeks on further **Clinical Attachments,** which were on average shorter than those of the third year, being one or 2 weeks long, in which they attended *'clinics in a variety of specialities, for which there are a number of associated lectures' (ibid*, p.49).

In **the fifth year** students again rotated around 6 **Clinical Attachments.** The specialities replicated 6 of those studied in year three, but this time teaching was, *'based largely in hospitals outside Southampton. Most of the teaching is on a one to one basis with the Regional Consultants' (ibid*, p.65).

Each course had its own coordinator, and there was an overall coordinator for the first 2 years, and for each of the third, fourth, and fifth years.

Most students studied the course over 5 years, although it was possible for students with previous experience of independent project work to complete in 4 years by skipping the clinical electives and the fourth year Project, and collapsing the clinical attachments of the fourth and fifth year.

THE RESEARCH PROCESS

The sample

Some limits had to be put on the number of respondents to interview, as the numbers of staff involved in teaching the undergraduate curriculum was very large. It was decided to interview all the course and attachment coordinators (using, as the definition of a course or attachment, the categories employed in table M1, the course outline produced by the Medical School) plus some other key informants, in an attempt to achieve coverage of whole curriculum. This was then a purposive sample (Morse, 1989; Miles and Huberman, 1994).

It was thought sensible to probe further in areas that it was reasonable to assume might be likely to be particularly central to the teaching of health promotion and health education. So all the staff who taught on the undergraduate course were interviewed from the Public Health Medicine group and the Primary Medical Care group, and two previous coordinators from Psychology as well as the current coordinator. Unfortunately only one Sociology coordinator could be interviewed, as the previous one had left.

Table M2 gives a summary of who was interviewed.

The pilot interviews

Finding staff on whom to pilot interviews was something of a challenge, as all the course coordinators needed to be interviewed, and many of the questions needed someone with an overview of the course in question. An opportunity presented itself in relation to the Foundation term, which, in addition to having an overall coordinator who was interviewed for the main study about the Foundation course as a whole, was divided into subthemes, each with its own coordinator. So these 5 sub-coordinators were the subject of pilot interviews. In order to pilot the interview on at least one clinical coordinator, a previous but recent coordinator of the third year Psychiatry attachment was also interviewed.

The pilot interviews used a rather more open ended schedule than the one that was eventually arrived at, and the pilot assisted in refining and focusing some of the questions.

The pilot interviews demonstrated the importance of asking all the questions, rather than assume that if a respondent touched on an issue early on, that they had said all they had to say about it.

One fairly fundamental change was made to the questions asked. An original intention had been to look at whether staff thought that the medical school had changed over the last ten years or so, to become more or less supportive of a health promoting perspective. Therefore

Table M2: Who was interviewed

Scope	Course	When	Who was interviewed	Number
Course as a whole			Overall coordinator of the medical curriculum Head of teaching quality assessment (also coord. of term 4 Head of medical education (staff development)	3
Whole years			Coordinator of first two years (also coord. of term 1) Coordinator of third year Coordinator of fourth year (also coord. of 4th year project) *(No fifth year coordinator existed)*	3
Individual Courses	Basic science courses	First two years	Coordinator s of terms 1 - 6 (for names of terms see table M1)	6
		Third year	Coordinator Scientific Basis of Medicine	1
	Clinical courses	First two years	Coordinator of Early Patient Contact Primary Care: Coordinator of Early Patient Contact Human Reproduction	2
		Third year	Coordinator Clinical Foundation Course	1
			Coordinators of Medicine, Surgery, Child Health, Obstetrics and Gynaecology, Palliative Medicine, Psychiatry, Geriatric Medicine	7
			Primary Care: Coordinator 4 other teachers Teaching administrator (also coordinator of EPC)	6
		Fourth year	Coordinators of Dermatology, Eyes, Genito-Urinary, Neurology, Orthopaedics, ENT	6
		Fifth year	Coordinators of Child Health, Primary Care, Medicine, Obstetrics and Gynaecology, Psychiatry, Surgery (3 also coord. of 3rd year attachments)	6
	Student project	Fourth year	Coordinator of Study in depth	1
Themes running through courses	Across the basic scien.s	Mostly years 1 and 2, with PHM contributing in year 3 to SBOM	Public Health Medicine 6 staff, including overall coordinator of teaching	6
			Psychology: current coordinator of teaching, and previous 2 coordinators	3
			Sociology: coordinator of teaching	1
Total number of people interviewed				46
Total number of elements (years, courses, attachments) represented				52

the original interview schedule asked at several points how the course in question had changed as regards the issue under discussion. However, this did not appear to be a meaningful question to most respondents, as most of them said they had not been course coordinator for more than a few years. Investigation showed that this was indeed the case with most of the coordinators, so it was decided to focus on the here and now, and take a snapshot of the current medical school, rather than attempt to take a long term perspective.

A smaller, but signficant, change was in the wording of one question. Originally it had been intended to use the words '*psycho-social*' when asking about how and to what extent psychological and social issues were taught in courses and attachments. The term worked well with staff who coordinated the basic sciences, with psycho-social scientists and Public Health Medicine staff. However, the term did not appear to tap into the right concepts and meanings when used with clinical staff. Some of them looked mystified and asked for clarification of what was meant, while others launched into a critical commentary on the psycho-social sciences themselves, rather than addressing whether psycho-social issues were looked at in their course. A clue was provided by those who did respond positively, who then used the word *'holistic'* in their replies rather than *'psycho-social'*. When the author then used the word *'holistic'* in subsequent interviews with clinicians, it produced more appropriate replies, that were concerned with how social and psychological issues were taught in that attachment. So, in practice, the author used both words in the question.

The issue of the different connotations the two terms had for staff is of interest to this thesis, and will be looked at in the findings and the discussion.

Analysis of the medical curriculum book and course outlines of Public Health Medicine, Psychology and Sociology

The other source of data was the medical curriculum booklet, which was a 78 page booklet with a one or two page outline of the aims, content and methods of each course, which given to students on their arrival. It had the advantage of employing fairly standardised entries for each course, allowing each about the same amount of space and of using mostly the same headings for each, which allowed some attempt at systematic analysis and comparison between courses.

As three of the areas of particular interest to this research, namely Public Health Medicine, Psychology and Sociology did not have entries in the medical curriculum book, their course outlines were analysed. These were short accounts, of 5 pages or so, of the aims, objectives, and content of these courses.

What was not done

The author had originally planned to triangulate the assertions made in interview with an

analysis of curriculum materials, and to this end all handbooks and handouts that related to courses were collected. However, it was obvious once analysis of the interview data was started that to devote space to this other large task would detract considerably from the richness of the interview data that could be included, and the author was keen to look at the curriculum, and the key issues around health promotion, from the point of view of the staff. It was felt that spontaneous staff replies to questions would give a better measure of what was really important to them, in terms of what they could recall and what they prioritised, than the more consciously 'constructed' curriculum materials. Furthermore the curriculum material was extremely varied in style, approach and length and therefore raised considerable problems for comparative analysis. The interviews, which asked the same questions of all, and the medical curriculum booklet with its fairly standardised entries for courses, provided more reliable data.

The invitation

Using the medical curriculum book as a guide, all the staff who were the target of the interview were sent a letter (appendix 1). This letter was deliberately kept short. It was felt best to be open about the intention of the interview to look at health promotion, not least because the thesis would be a matter of public record in the University in question, but the letter also mentioned that the interview would look at the curriculum as whole, as well as specific content. Given that doctors are seen as an 'elite' it was thought wise to emphasise the status of the interviewer in the University, (Dexter, 1970; Platt, 1981; Ostrander, 1993) so the letter was sent from 'the director of the health education unit', mentioned that a previous, similar study by the author was published previously, and used secretaries as intermediaries to fix the appointments.

In the event, no-one refused to be interviewed, and all were indeed very generous with their time and attention.

The position of the author

A key precept of qualitative research is that the researcher is not a neutral figure, but has themselves an impact on what they research (Hammersley and Atkinson, 1994; Burgess, 1984), so a few reflexive observations on the position of the author in relation to the subjects seem to be in order.

From 1984 to 1989 the author had worked half time in the Medical School as a lecturer in the then Community Medicine group (since relabelled Public Health Medicine). At that time she carried out a curriculum review of the teaching of health promotion across the Medical School from which she developed health promotion inputs in a range of courses, including Community Medicine, Primary Medical Care, and the Respiratory Systems course. Later, by then full time in the Faculty of Educational studies, she worked with

colleagues in the Medical School in a variety of capacities, most extensively with the Primary Medical Care group, helping them develop their third year teaching manual, identify their key competences, and develop a pilot course on anticipatory care for year 2.

So the author was fairly well known to staff in the medical school. This perhaps gave her access and cooperation to an extent that might have been denied to an outsider. However, it was clear from the outset that she was going to take steps to try to ensure that staff did not just tell her what they thought she wanted to hear about the extent of the teaching of health promotion. Several efforts were made to reduce this possibility, for example in her preamble to the interview she emphasised her role as an education rather than as a health promotion specialist, began the interview with some general questions about the course in general, and took care to phrase all questions about potential content areas in a neutral manner (Breakwell, 1990; Gordon, 1990).

Using an ostensibly structured interview

One of the key features of a qualitative approach is that the context in which the data is collected should be one in which the subjects of the research behave fairly naturally (Burgess, 1994; Mishler, 1986). The interviews were invariably carried out in the respondent' offices, at a time to suit them. Being doctors and/or academics, they were used to such semi-formal encounters as interviews, and relatively at ease in this kind of setting. Doctors are busy people, used to the experimental and the positivist paradigms of research (Jelinek, 1991) and it was thought that they would feel more at ease with an interview that appeared to start at least with a clearly structured set of questions. However, as will be apparent when we look at the techniques used in questioning, the questions used were in fact more open ended starting points for discussion, rather than a rigid, structured interview. The justification for using open ended and exploratory approaches has been made earlier in this chapter.

The questions asked, their wording and order

What follows is an indication of the key questions asked, and the wording that the author tended to use.

A copy of the interview schedule that was used is given as appendix 2. The significance of most of the questions asked should evident from the rationale chapter, and so this section will not provide a justification of each question, but simply give a rationale for any question the significance of which does not seem obvious, and provide a commentary on question order and wording.

All coordinators were asked these questions in relation to the year, course or attachment they coordinated, while the overall medical curriculum coordinator was asked them in

relation to the course as a whole.

Questions about the course in general

After the usual preliminary niceties, for example checking that the person being interviewed was indeed the course coordinator and understood the purpose of the interview, the interview proper started with some general questions about the aims, content and teaching methodology of the course or attachment in question.

- ***What are the aims of the course/ attachment?***

- ***Can you give me a 'thumbnail sketch' of the course/ attachment? What content does it cover? How is it structured?***

The purpose of starting with these general questions was threefold. First and foremost the author was trying to get a realistic picture of how central the concerns of the research really were to medical teachers. The author was aware how easy it is to get a false picture of the amount of interest in an issue by making it too obvious what the interests of the research are, so she was keen to find out what respondents thought they were teaching about in a relatively open and 'unsolicited' way (Hammersley and Atkinson, 1995). She was also keen to avoid 'prestige bias' (Oppenheim, 1992) in the answers, and felt that medical staff might have been tempted to make more of their teaching about, say, prevention and health promotion than they were actually doing in practice. So, by asking these general questions first, the author was trying to obtain data that would help her assess the relative importance of issues related to health promotion by discovering whether any such issues occurred naturally within more general answers at the outset of the interview, before more leading questions were asked about detailed topics.

Secondly it was hoped that asking about the course or attachment in general would help to minimise the author's own biases and preconceptions, by giving her information about the course as a whole and issues of importance to the respondents, to consider alongside her own preconceived areas of interest which would help her adapt and expand her view of the research problem in unexpected ways (Kahn and Cannell, 1961).

Finally and pragmatically, given that health promotion and health education and related issues were thought to be issues that might not prove important to many of the respondents, these questions gave all respondents something to talk about freely and get the interview off to a good start (Gordon, 1990).

- ***How is the course taught? What methods do you use?***

The rationale chapter suggested that the 'hidden curriculum' of curriculum processes is an important issue to examine in relation to health promotion, and this question attempted to explore it in terms of the methods of teaching and learning that were used on the course, and the assumptions and values that accompanied them.

Questions on specific aspects of course content

- ***Turning now to some of the areas in which I am particularly interested, such as health, health promotion, social issues and so on....***

This introduction was an attempt to flag up a change of direction in the interview, and prepare for the kind of issues in which the researcher was particularly interested.

- ***To what extent does the course take a holistic view and/or cover psycho-social issues?***

The pilot interviews suggested that holism was a familiar idea to most staff, and so this was intended to be an appropriate first question for this more detailed and focused section.

- ***Does this course include anything on prevention?***

- ***Is there any work on 'healthy lifestyles'?***

As we have seen, prevention was thought to be the aspect of health promotion that most doctors find easiest to identify, so this seemed again a 'safe' issue to ask about before looking at health promotion under its own name. It was thought to be important to distinguish health promotion from prevention, and so the issues were asked about separately.

- ***Does this course include anything on health promotion, that you have not mentioned already?***

Although it seemed likely that health promotion would not be prominent, it seemed important to ask about it under its own name, to ensure that any instances of its appearance were noted. It was also thought to be useful as a way of seeing what staff meant by the terms, and what their attitudes were towards them.

- ***It is often said that the medical curriculum is essentially about disease and illness.***

Do the students get any messages about positive health, normality, or well being?

- *Is there any sense in which the students' own health is mentioned?*
- *Does the course teach communication skills at all?*
- *Do the students see any examples of teamwork or work with other professions on the course?*
- *Is any use made of community as the context for teaching?*

The significance of these questions in this section should be evident from the rationale chapter. They were all fairly straightforward attempts to discover whether issues that this thesis considers to be of importance to health promotion (although it was considered unlikely that many of those interviewed would have thought of them as such) were taught in the medical curriculum.

- *Do you hope the students will acquire any particular attitudes to patients?*

There was, deliberately, no explicit question on 'patient centredness', as the author wanted to see whether it cropped up naturally. It was thought that this question on 'attitudes' was sufficiently directly related to this issue to trigger answers that tapped into their views on patient centredness if this issue was of significance to the respondent.

- *How are students assessed?*

The rationale section suggested that forms of assessment were likely to be influential over student learning and attitudes in the same way that methods of teaching and learning were.

- *How do students give feedback on the course?*

This question was designed to discover the extent to which staff took the views of the students seriously, as some measure of their 'student centredness'.

- *Are any particular attempts made to integrate this course with any other, vertically or horizontally?*

This question was asked because the author was interested to discover the degree of integration in the course in general, and within the psycho-social sciences in particular,

partly to discover whether the context was favourable for the use of the kind of 'integrated' models of health promotion currently in favour.

Final questions

- ***Have you any wider thoughts....***
  - ***On the course we are looking at?***
  - ***On the year in which the course takes place?***
  - ***On the medical course at Southampton?***
  - ***On medical education in general?***

These questions were asked in order allow the respondent to provide any final thoughts that might put the more detailed comments in a wider context, and to give her or him an opportunity to elaborate on any previous answers. The author was particularly interested on any comments on educational issues that might give insights into the 'hidden curriculum' of the educational processes and assumptions that underlay the taught curriculum.

- ***Is there anything you feel I left out that I should have asked you?***

This was asked to give the respondent an opportunity to talk more about any issues that interested them, and to fill in any gaps and omissions they perceived.

How the questions were asked

The author used the interview schedule (appendix 2) as a reminder to herself of what she needed to ask about. When appropriate she asked the questions as scripted, and in the order in which they were written. However, in the interests of keeping the interviews as 'natural' as possible, she often paraphrased them to echo the language and style of the respondent, or asked them in a different order, particularly as the interview progressed and she was attempting to pick up and connect with the respondent's train of thought (Gordon, 1990; Oppenheim, 1992; McCraken, 1988).

No issues were left out, as the pilot interviews showed that it was not safe to prejudge that question would prove to be irrelevant on the basis of earlier responses, or to assume that an answer which appeared to have covered the topic incidentally had covered all the respondent wished to say.

The style adopted by the author/ interviewer was designed to attempt to bias the respondent's answers as little as possible (Brenner, 1985; Breakwell, 1990; Powney and Watts, 1987). She asked the question, and, as far as possible let the respondent talk as freely and for as long as they wished without interruption. Again in an effort to keep the conversation 'natural' and to attempt to ensure that she had probed as deeply as possible, the author engaged in the kind of brief rephrasing, repetition of answers, requests for clarification and associated questioning that attempted to keep the respondent on the topic until it appeared that they had said all they wished to (Mishler, 1986). She attempted to keep all such follow ups brief and tentative, in order to shape the responses as little as possible (McCraken, 1988). Similarly, throughout the interview she tried to keep her comments to a minimum, and in particular not to express an opinion. If the respondent's manner seemed to be demanding a response, then she attempted simply to be mildly positive and affirming (Brenner, 1985).

Although the interviews were tape recorded, notes were also made on the schedule to help the process of the interview. These mainly noted issues that were touched on early and would thus need acknowledgment when returned to later, noted interesting points made in 'mid flow' by the respondent to which the author intended to return, and recorded factual information, such as suggestions for who the author should talk to, that might need immediate action after the interview and before the tape was transcribed.

DATA ANALYSIS

Recording the interviews

Most who write about qualitative interviews assert that tape recording rather than note taking is essential if data are to be gathered as fully and unobtrusively as possible (Powney Watts, 1987), as objectively as possible (Oppenheim, 1992), and then subjected to systematic analysis (Miles and Huberman, 1994). So all the interviews were taped, except for one where the respondent declined: in this case full notes were made and used as the basis for taped and transcribed dictation immediately after the interview.

Transcription

The tapes were transcribed by a secretary immediately after the interview. As soon as possible after that, and always within a week of the interview, the author listened to the tapes and looked at the transcript, which was in the form of a text file on her computer. During this first listen through she corrected transcriber mistakes and reminded herself of the 'gist' of what was said.

Analysis of the aims of the curriculum

In order not to lose sight of the overall curriculum, and to provide a sense of perspective on the issues of most central interest to this thesis, a detailed analysis of all the aims of the medical curriculum was undertaken.

For this exercise, all the written aims of the curriculum, as stated in the medical curriculum book, and all the oral statements of aims, given in response to the interview question *'what are the aims of your course?'* were analysed according to the issues they covered. In order to attempt some comparability between courses, the data included in this section were restricted to what was written in the medical curriculum booklet under the headings called there *'aims'* and what was said in interview in response to one of the introductory questions, *'what are the aims of this course?'* In order to bring aims from different courses and from the interviews together some paraphrasing was necessary, but this was kept to a minimum, and the spirit, the intention, and as far as possible the original words, were retained.

The results of this analysis are given at the beginning of the next chapter on 'findings', where they are summarised in table F1. Appendix 3 gives a detailed breakdown of the aims according to how they appeared in the separate courses, while appendix 4 gives examples of how the original verbatim aims were categorised.

This analysis of aims also contributed to the construction of the framework being used for analysis, which will be described next.

Constructing a framework for analysis

The key task for the qualitative researcher is *'identifying and linking analytic categories'* (Dey, 1993). So a key part of the analysis was building up a framework of such analytic categories that both reflected the original research objectives and questions asked in the interviews, and also reflected emergent categories which were based on the ways of thinking and the concerns of the staff that could not have been anticipated. Table M3 shows the final framework that was arrived at. It attempts to make clear which categories were in place from the outset, and which emerged from the data.

The basic methods used were a mixture of content analysis (Krippendorff, 1980) and thematic analysis (Miles and Huberman, 1994). The framework was initially constructed from the questions asked in the interview, which continued to provide many of the broad headings of the framework. Several initial readings of all the transcripts lead to the subdivision of some of the categories of the framework, the addition of some further main headings and many subheadings.

Once a preliminary version of this framework was in place, the task became *'the*

Table M3: Overall framework arrived at for the analysis of the interview data

Key:

Brackets () = Category not included in final write up
* = Category emerged from the data - if no * then category in place at outset
'Element'= Means course, clinical attachment or year in question

Questions asked that gave rise to most of the answers in this category	**Main category** used for analysis	**Subcategory**
What are the aims of course/ attachment/ year?	Aims of the element	What the aims were - examples of how the aims were categorised is in appendix 4.
		Relationship of aims to aspects of health promotion
Can you tell me about the course? What content does it cover? How is it structured?	What happens in this element?	(Overall content and structure)
		Relationship of content to aspects of health promotion
		(Timing of the course)
What changes have been made to the course in recent years?	Changes	(Changes to the element)
		Relationship of change to aspects of health promotion
	(Status - status of psycho-social, PHM and PMC analysed separately below)	(* Status of the element in the University)
		(* Status of the element with the students)
Does this course include anything on health promotion?	Health Promotion	*Concepts of health promotion - broken down in table F7
		*Health promotion in the course as a whole
		Health promotion in the element in question
		*Status of health promotion
Does this course include anything on prevention?	Prevention	*Prevention in the course as a whole
		Prevention in this element
		*Nutrition
		Lifestyle
		*Status of prevention

Does the course take a population/ public health approach?	Taking a population approach	Epidemiology
		Risk
		*Using a 'low tech' approach
Do the students get any messages about positive health, normality and/or well being?'	Health and normality	*Health in the course in general
		Health in this element
		*Health in medicine as a whole
		*Relative health
To what extent does the course take a holistic view/ cover psycho-social aspects?	* Holism	*Holism in the course as a whole
		* Holism in this element
	Psycho-social perspective	*Psycho-social across the curriculum
		Psycho-social in this element
	Social	*Patient's social context
		Broader social issues
		Healthy public policy
		Social change
Do you hope that the students will acquire any particular attitudes to patients?	Patient centredness	*Patient centredness in the course as a whole
		Patient centredness in this element
		* 'Challenging' patients
	* Critical thinking (see separate category below)	
Does the course teach communication skills?	Communication with patients	*Communication in the courses as a whole
		Communication in this element
		Empowerment
	Students own communication skills	

Is there any sense in which students' own health is mentioned?	Students' own health	* In the Medical School as a whole
		In this element
Tended to arise from questions on *'aims' and attitudes'*	*Critical thinking	*Critical thinking in general
		*Being critical of medicine
No specific question asked: arose naturally	*Ethics	
Do the students see examples of teamwork/ work with other professions?	Teamwork	
	Multi-professionalism	
Is any use made of the community as a context/ subject for teaching?	The Community	*Shift to the community by the medical school
		Teaching in the community in this element
		Teaching about the community in this element
What methods do you use on the course? *How have they changed over recent years?* *Has there been any more to make them more student centred and/or active?*	The Hidden Curriculum	*General comments on methods in the element
		Student centredness
		* Self directed learning
		* Responding to students' problems
		* Problem based learning
		* Using information technology
		* Lectures
		* One to one
		* Group work
		* Tutorials
		* Whole group practicals
		* Apprentice/ modelling
		* On the wards
		* Case presentations
		* Other methods
		* Level of staff autonomy
How are the students assessed?	Assessment	* Comments on assessment in general
		Assessment in this part of the course
How do students give feedback on the course?	Student centredness	* Comments on student feedback in general
		Student feedback in this part of the course

Have you any wider comments? *What methods do you use on the course?*	The Hidden Curriculum	* Medical education in general
		Education in this medical curriculum
Various questions, especially: *Are any attempts made to integrate this course with any other?* *What changes have been made to the course in recent years?* *To what extent does the course take a holistic view/ cover psycho-social aspects?*	* Status of psycho-social sciences	*Integration of with rest of curriculum
		*Student attitudes
		*Attitude of medicine
		*Clash of cultures/ epistemologies
		*'Commonsense'
		* Teaching methods
		* Status of Psychology and Sociology
		* Psycho-social staff ambivalence
		* Better taught by staff in medical school
		* The 'integrated course'
	*Status of Public Health Medicine	*Status in the University
		* Status with students
	* Status of Primary Medical Care	*Status in the University
		* Status with students
Are any particular attempts made to integrate this course with any other? (Nb categories used to analyse this question in relation to PHM, Psycho-social science and PMC is in the row above)	Integration	(*Integration across the medical curriculum)
		(* Integration within this element)
		(Integration of this course with the rest of the curriculum
		*Integration between the first two years and the rest
		(*Integrating work in Uni. with practice)
		(*Integrating this element with hospital medicine)
		*Effect of fourth year project

categorisation of data, and the assigning of data bits to themes and codes' (Coffey and Atkinson, 1996). The author used the copy and paste facility of a straightforward word processing package, extracting excerpts from transcripts and pasting them under the relevant category in a data file. Each excerpt was clearly labelled with the element to which they related, so they could be traced back to the original transcript. Many ideas and extracts were pasted under more than one category. In contrast to using specialised computer software, this method was labourious, but as Maykut and Morehouse (1994) assert, it had the advantages of helping construct the framework in an iterative fashion, and of staying close to the data.

In order to prevent the files becoming too unwieldy, the interviews were analysed in batches in 6 separate but parallel files, with one file each for: the first two years; the third and fourth years; the fifth year; Public Health Medicine; Primary Medical Care; and the psycho-social sciences. Within the headings of the framework, each element (year, course, or attachment) was analysed separately.

As Woolcott (1994) has pointed out, the imposition of categories on data is in itself a first act of what he sees as a total process of data '*transformation*'. So the formation of the overall framework itself, with its categorisation, ordering and linking of themes and topics formed the first stage in the interpretation of the data.

The extracts pasted into the framework were usually verbatim quotes, sometimes paraphrases with page references to the transcript. At this stage the author continued to work with such verbatim extracts, rather than employ a second order 'code and retrieve' system (Miles and Huberman, 1994) which she felt risked divorcing her from the real life words of staff and making premature judgments about the data. To guide her thoughts in this potentially overwhelming endeavour, she added an ongoing commentary, which reminded her of the rationale for what was pasted in which category and which 'bits' of data were clustered together. This commentary also added to the process of interpretation, of examining data '*in terms of the patterns and connections that emerge'* (Coffey and Atkinson, 1996) or, as Dey (1993) has put it '*putting mortar between the building blocks'*, by providing preliminary thoughts on the apparent trends and links that were emerging.

In an attempt to reduce the author's bias, and to give the author the full range of data on which she could then reflect, all utterances (except those of social chat) contributed to the construction of an overall framework and were fitted into it, whether or not they were connected ostensibly with the objectives of the thesis, and whether or not it was envisaged that they would form part of the final write up. So all the data was put somewhere.

Following the tradition of 'grounded theorising' the framework was gradually modified and

added to as the analysis proceeded. In the early stages this required some considerable ongoing rethinking of categories, re-organising of extracts, and returning to transcripts already analysed to apply the new categories that had emerged. However, as the framework became more secure, 'saturation' of categories (Glaser and Strauss, 1967) was gradually achieved, and the need for this rethinking and re-analysis eventually disappeared. However, the author then continued to work right through all 51 transcripts, copying and pasting all examples of the categories into the framework. A qualitative approach does not preclude the use of numbers, as all research, however qualitative is, ultimately, about counting occurances (Miles and Huberman, 1994), and the author was keen to ensure that she could report not only what the categories were, but how they were distributed across all the respondents, so that the final write up could include information, not only on what staff said, but exactly how many said what.

Choosing the categories about which to write

The original 6 files, with their emergent categories, their copied and pasted verbatim and paraphrased interview extracts, and preliminary commentary were extremely large, about 180,000 words in all. It was clear that some fairly ruthless selectivity had to be exercised, as is invariably the case with qualitative research (Goertz and LeCompte, 1981)

Table M3 attempts to make clear which of the categories that were included in the initial 'copy and paste' exercise were used in the final write up of the findings. Some of the questions in the interview schedule, for example on course structure and timing, had never been intended to be written up: they had always been there simply as warm up questions and to guide the author in her attempts to understand the overall curriculum. So these questions were not included in the final analysis.

Data summary and further interpretation

Up to this point the framework had been partly descriptive, labelling what staff felt was in the curriculum and where it might be found. More conceptual issues tended to emerge at the following stage, and from here on the analysis became rather more interesting.

All the extracts from all 6 files that came under a category were copied and pasted together under that category, a category at a time. The task became to turn them into text which drew out the concepts and opinions that staff appeared to have and gave an account of the range of views on them. This was done directly from the pasted extracts, without the need formally to amend the framework by adding further subcategories to it.

For most of the categories it made sense to organise the data chronologically within each section, starting with the basic science teaching of the first and second years, into which the Public Health Medicine and psycho-social science could be woven, and then going on to the

clinical attachments of the third, fourth and fifth year, into which Primary Medical Care was fitted. This straightforward structure had the advantage of retaining clarity for the reader in what might otherwise have been a very confusing account.

Wherever possible, tables were constructed, which attempted to tabularise succinctly what the medical curriculum book and staff in interview appeared to be saying about this issue. The results of the analysis of 'aims' were added into each section and table as appropriate, with all the relevant aims being quoted, verbatim, in the table. These tables were for summary purposes only, and the numbers in them, and in the text, were never intended to be subjected to statistical analysis. The intention of the research was to identify suggestive trends and tendencies only, not to investigate statistically significant differences between subgroups of respondents.

Counts of keywords

As the analysis progressed, it was realised that some key words that were of interest to the thesis kept cropping up in the interviews. So word counts were carried out on such words, as an additional indicator of how meaningful and central some of the key idea appeared to be. This was done by searching the transcripts of the interviews for the words in question and closely related words, using the 'find' command in the word processing package. The findings of these key word searches were tabularised, commented on, and included in the relevant sections of the findings chapter. Information on which words they were, and what was included is in the notes to the tables themselves, which are tables F4, F6, F9, and F13, and will be found in the findings chapter.

Categorisation of subjects and specialties according to status

In the analysis of findings, a concept that will be employed is the 'status' that particular subjects and specialties enjoyed, and areas will be categorised as having 'lower' or 'higher' status in relation to one another.

There has been a little generic research on the perception of medical students of various medical specialties (Bruhn and Parsons, 1964, 1965; Matteson and Smith, 1977; Furnham, 1986), and some more specific work on their perceptions of particular specialties, especially those thought to suffer from problems, in particular Psychiatry. The picture that emerges is a complex one. For example, as Matteson and Smith (1977) have shown, the status a specialty is thought to possess is not the same issue as which specialties students prefer to study, and subject preference is again not the same as students' eventual career choice, which is often determined by very pragmatic issues, such as their perception of their own abilities, and how it will fit in with their lifestyle. Nevertheless, a broad picture emerges of the status and image that various specialties are thought to have by medical students.

Some areas are clearly high status. Furnham (1986) found that medical students perceived both Hospital Medicine in general and Surgery and Paediatrics in particular as having high status within medicine, and as being scientific and precise, a good use of medical education, and important for medical students to learn. These findings are supported by Bruhn and Parson's earlier work (Bruhn and Parsons, 1964, 1965) and more recent work by Mattson *et al* (1991).

Several specialties appear to have lower status. Psychiatry has the worst image of the clinical specialities. Various studies agree that medical students see Psychiatry as having a low status within medical profession, and being unscientific, not an important part of the medical curriculum, and unpopular with medical students, while, unlike all other clinicians, Psychiatrists are seen as being unpopular with the general public and emotionally unstable themselves (Bruhn and Parsons, 1964, 1965; Furnham, 1986; Creed and Goldberg, 1987; Soufi and Raoof, 1992). There have been recurrent efforts to make Psychiatry more attractive to medical students (Galletly et al, 1995) and help students feel more positive about it, but none appear to have met with any great success.

Geriatric medicine would appear also to suffer from something of a poor image, with students tending to be negative about the elderly and disinclined to work with them (Perrotta *et al,* 1981; Peach and Pathy, 1982; Traines, 1991).

Several surveys have shown that medical students find Palliative Care a difficult and demanding specialty (Hull, 1991; Field, 1984) and there have been several calls for it, and the skills it represents, such as emotional sensitivity and expressiveness, and breaking bad news, to be more widely taught (Sykes, 1989; Charlton 1992; Smith, 1992, 1995). Although Palliative Care has doubled the amount of time spent on it in medical education from 6 hours on average per course in 1983 to 13 in 1994 (Smith, 1995) and is now taught in almost all medical schools, the time spent on it in courses is still relatively short.

Primary Medical Care would seem to enjoy a mixed image. Students agree that it does not enjoy a high status within medicine (Bruhn and Parsons, 1964, 1965; Furnham, 1986; Mattson *et al,* 1991) seeing it as marginalised in comparison with Hospital Medicine and Surgery. However, it is clearly popular with students, who very much enjoy learning it, see it as a good use of a medical education, and in need of more time in the medical curriculum (Mattson et al, 1991; Furnham, 1986). They also see it as increasing in status in recent years, and as at the frontier of medicine (Furnham, 1986). It was at one time an extremely popular specialty as a career, especially for women, but the recent changes of the 'new contract' are perceived by doctors as increasing the stress and demands on General Practice and have caused a significant drop in the numbers of students going into the discipline (Richards, 1992; Sutherland and Cooper, 1992).

It is very clear that Public Health Medicine and the psycho-social sciences tend to have a lower status than both the bio-medical sciences and clinical specialties in the minds of both medical students and medical staff, and that Sociology has a lower status than Psychology, while both have a lower status than Public Health Medicine (GMC, 1987b; Ewan, 1987, 1988).

The status enjoyed by different areas of the curriculum is then clearly a complex picture: status is a relative, not an absolute concept, and, apart from the two extremes of Surgery and Sociology, most specialties can be conceived of as having a higher status than some and a lower status than others. The following table attempts to portray the dichotomies that appear to exist, and will be used in the analysis of the findings.

Table M4 The relative status of specialties and subjects

Higher status	Lower status
Hospital specialties	Primary Medical Care
Surgery, Medicine and Paediatrics	Primary Medical Care, Geriatrics, Psychiatry, Palliative Care
Biomedical sciences and clinical specialties	Public Health Medicine and the psycho-social sciences
Public Health Medicine	The psycho-social sciences
Psychology	Sociology

CHAPTER THREE

FINDINGS

PART ONE:

HEALTH, HEALTH PROMOTION AND PREVENTION

Structure of the findings chapters

For ease of reading, the findings chapters have been divided into three parts: this chapter concerns itself with how staff viewed issues usually seen as most central to health promotion in the context of medical education, namely health, health promotion and prevention. The second and third findings chapters will look at issues which the rationale chapter saw as related to health promotion, but which medical staff do not tend to associate so readily with it, such as psycho-social issues, holism, patient centredness, communication, the role and power of the doctor, teamwork, Primary Medical Care and the community.

The objectives that were arrived at in the rationale chapter will be restated at the beginning of the section to which they most clearly relate. They will again be printed in ***bold italics.***

THE AIMS OF THE MEDICAL CURRICULUM

The significance of aims to staff

- ***This thesis will attempt to discover what medical staff were trying to achieve in their teaching, as the starting point for uncovering the links and overlaps in the relationship between the medical curriculum and health promotion.***

The rationale and methodology chapters argued that in attempting to find areas of overlap between medical education and health promotion it is important to begin where staff are and understand their perceptions and intentions.

The idea of having aims appeared to be a highly relevant and current issue to those who managed the medical curriculum. For example, the overall coordinator of the medical curriculum, when asked how Southampton compared with other medical schools, nominated its aims, *'I think that we do have basic aims which are good'*. The 6 staff who were in various ways responsible for leadership and the overall organisation of the curriculum (the

overall coordinator of the medical curriculum, the head of the Teaching Quality Assessment (TQA), the Head of Medical Education and the three year coordinators) all claimed that they had put a good deal of effort into encouraging those responsible for courses to think through their aims. They reported that staff were beginning to respond: for example, talking about her medical teacher colleagues, the head of TQA said, *'they are better at thinking about aims and objectives, and the people that have undergone TQA actually do it'*. So, each of the courses had a set of written aims, which were to be found in the medical curriculum book and were repeated in course materials.

Responses in the interviews also suggested the idea of curriculum aims had a great deal of currency. When asked '*what are the aims of your course?*', no respondent had difficulty answering. Most gave a fairly full reply, in many cases with attendant discussion on the amount of effort they had put into determining the aims, and how important they felt they were for student learning.

So an analysis of the aims of the curriculum seems to provide a meaningful way to gain an overview of the medical curriculum, and a sense of perspective about how issues connected with health promotion related to the curriculum as a whole.

Issues covered by aims

In table F1 all the written aims of the curriculum, as stated in the medical curriculum book, and all the oral statements of aims, given in response to the specific interview question *'what are the aims of your course?'* have been analysed according to the issues they covered. This table attempts to provide a foundation for the more detailed analyses that follow. An account of how this overall table was built up, which gives a breakdown of the aims according to how they appeared in the separate courses will be found in appendix 3 and examples of how the original verbatim aims were categorised will be found in appendix 4.

In pursuit of an inclusive overview of the curriculum, all aims mentioned in the medical curriculum book and in interview have been included in table F1. In order to bring aims from different courses and from the interviews together some paraphrasing has been necessary, but this has been kept to a minimum, and the spirit, the intention, and as far as possible the original words, have been retained.

31 individual aims could be identified, and have been grouped in this table according to the demarkation lines used most often by those who organised the medical curriculum, namely the *'basic sciences'*, *'clinical skills'*, *'psycho-social /holistic issues, patient centredness and Public Health Medicine'*, and the process of *'learning'*, while those relating to specific topics were listed under '*about other issues*'. There were furthermore some aims which

Table F1: Aims of the medical curriculum[1]

Key: √ = written in medical curriculum book ☺ = said by coordinator in interview

learning..	COURSE AIMS: learning.....	Basic science[2] 8 elms	Clinical courses[3] 25 elms	Year 4 proj	Whole course[4] 35 elms
....the basic sciences	knowledge and understanding about the body/mind	√6 ☺ 7	√2		√10 ☺ 8
	to understand disease (stated specifically)	√5 ☺ 2	√4 ☺ 3		√10 ☺ 6
	about normality (stated specifically)		√4 ☺ 2		√ 5 ☺ 3
	integrate the basic sciences with clinical practice	√5 ☺ 5	√8 ☺ 5		√14 ☺ 11
	total *'learning the basic sciences'*	√16 ☺14	√18 ☺10		√39 ☺ 28
	total number of elements mentioning	**8/8**	**16/25**	**0/1**	**25/35**
..about medicine	about medicine as a whole/ general medicine		√1 ☺ 4		√2 ☺ 5
	about a particular speciality/ service		√6 ☺ 9		√6 ☺ 9
	total *'learning about medicine'*	0	√7 ☺ 13		√8 ☺ 14
	total number of elements mentioning	**0**	**13/25**	**0/1**	**14/35**
...clinical skills	to take a history and do a physical examination		√20 ☺16		√21 ☺17
	to diagnose/ detect disease		√ 14 ☺ 9		√ 15 ☺ 10
	about the management / treatment of disease		√10 ☺ 5		√12 ☺ 6
	'clinical skills' (details unspecified)	☺ 3	√6 ☺ 5		√7 ☺ 9
	total *'learning clinical skills'*	☺ 3	√50 ☺35		√55 ☺ 42
	total number of elements mentioning	**3/8**	**23/25**	**0/1**	**26/35**
to take a psycho-social, patient centred and public health approach	to take a psycho-social/ holistic perspective	√2 ☺ 1	√8 ☺ 6		√11☺ 8
	about the determinants of health and illness	√2	√6 ☺ 3		√8 ☺ 3
	to take a patient centred approach	√2	√14 ☺ 9		√17 ☺ 10
	to have positive attitudes to particular patients		√2 ☺ 2		√2 ☺ 2
	to communicate with patients and their families	☺ 1	√6 ☺ 8		√7 ☺ 10
	role of the doctor	√ 1	√1		√2
	public health/ epidemiological perspective	√3	√3		√6
	about prevention	√2	√3 ☺ 2		√6 ☺ 3
	about lifestyle/ behaviour change	√1	√1 ☺ 1		√2 ☺ 1
	total *'learning to take a psycho-social, patient centred and public health perspective'*	√13 ☺ 2	√50 ☺22		√54 ☺ 37
	total number of elements mentioning	**6/8**	**17/25**	**0/1**	**24/35**

..to learn	(meeting) students own emotional/ social needs	☺2	√4 ☺1		√5 ☺ 4
	to learn/ self learning	√1 ☺1	√2 ☺1	√1 ☺1	√5 ☺ 4
	to think critically, to evaluate, to weigh evidence	√2	√3 ☺1	√1 ☺1	√7 ☺3
	to communicate with colleagues	☺1	√2 ☺1	√1 ☺1	√4 ☺ 4
	to reflect /to have a broader vision	☺3	√1 ☺1	√1	√2 ☺ 5
	total *'learning about learning'*	√2 ☺4	√6 ☺3	√3 ☺2	√23 ☺20
	total number of elements mentioning	**4/8**	**7/24**	**1/1**	**13/35**
..about other issues	about sexual health and disease		√1 ☺2		√1 ☺2
	about pregnancy, childbirth, development	√1	√3 ☺2		√5 ☺3
	about ageing/ death and dying		√2 ☺2		√3 ☺3
	about disability	√1	√1		√3
	about team working/ multi professional practice		√5		√ 6
	about ethics	√1	√4 ☺1	√1	√8 ☺2
	other/ one offs	√1	√ 2		√7
	total *'learning about other issues'*	√3	√18 ☺7	√1	√33 ☺10
	total number of elements mentioning	**3/8**	**11/25**	**1/1**	**16/35**

Notes

1. For the details of individual course aims from which this table was constructed, see appendix 3. For examples of verbatim course aims and how they were categorised, see appendix 4.
2. **Basic Sciences/ 8 elements** refers to:
   - Foundation term
   - 5 one term Systems Courses that ran through the 1st 2 years
   - Scientific Basis of Medicine Course in the 3rd year
   - Entry in medical curriculum book and comments by coordinator on the aims of the 1st 2 years.
3. **Clinical courses/ 25 elements** refers to:
   - 2 Early Patient Contact courses in the 1st 2 years
   - Clinical Foundation Course
   - 20 Clinical Attachments that ran over the 3rd, 4th and 5th year
   - Entry in medical curriculum book and comments by coordinator on the aims of the 3rd year.
   - Entry in medical curriculum book on the aims of the 5th year.
4. **Whole course/ 35 elements** refers to:
   - All the elements of the course, i.e. totals of the 1st 3 columns
   - Entry in medical curriculum book and comments by the medical education coordinator on the aims of the course as a whole.

appeared to be appropriately listed under a further general heading of *'about medicine'*.

The traditional mainstream '*clinical skills*' of history taking, diagnosis, and management of disease, were mentioned most frequently, 97 times, and by 26 of the 35 course elements. But the aims mentioned almost as frequently, 91 times, were those connected with '*psycho-social/ holistic issues, patient centredness and Public Health Medicine*', and they were mentioned by almost as many elements, 24 of the 35. *'Teaching the basic sciences'* was mentioned 67 times, across 25 of the 35 elements. Aims connected with *'student learning'* were mentioned 43 times, across 13 of the 35 elements; those connected with '*the teaching of medicine in general*' were mentioned 22 times, across 14 of the 35 elements. A range of *'other'* aims, concerned with specific issues, were mentioned 43 times, across 16 of the 35 elements.

So the curriculum had a wide range of aims, including the traditional ones of 'clinical skills' and 'basic sciences', but its aims were by no means restricted to those. The area of most immediate and obvious relevance to health promotion, namely *'psycho-social/holistic issues, patient centredness and Public Health Medicine'* was mentioned nearly as often as *'clinical skills'* and more often than '*basic sciences*'.

Teaching attitudes

A further useful indicator of staff intention was the responses given to another general question asked later in the interview, *'do you hope the students will acquire any particular attitudes to patients?'* These are analysed in table F2. For comparability, the responses included in this table are restricted to those given in answer to that specific question: at other points in the interview many staff talked further of the attitudes they felt were taught by their courses but they are not included in this particular section. A breakdown of which course coordinators nominated which attitudes will be found in appendix 5.

Attitudes to do with *'patient centredness'* were those most frequently mentioned, 22 times in all, using that specific term. There were also 4 mentions, all by clinically based staff, of the need to have '*positive attitudes*' to certain patients, and two mentions of the need to be '*respectful*' to patients; in both cases the criterion for *'respect'* was '*appropriate*' dress. *'Self learning*' was mentioned next most often, 12 times in all, especially in relation to the basic sciences, but also in relation to some clinical attachments, particularly in the fifth year. That, plus the 4 mentions of '*confident*' suggest that learning was important to staff across the curriculum. *'Multi-professionalism*' and '*teamwork*' were mentioned 4 times between them. 1 member of staff nominated the adoption of a '*critical perspective*', and one mentioned the need to convince students to *'look after their own health'*.

This list suggests that staff were trying to teach a range of attitudes, most of them linked to

Table F2: Responses to '*what kind of attitudes do you hope the students will learn on your course?*' [1]

Attitude	Coordinators of Basic Sciences[2] (8 elements)	Coordinators of Clinical courses[3] (25 elements)	Year 4 project (1 element)	Whole course[4] 35 elements)
Patient centredness	1	20		22
Positive attitudes towards certain patients		4		4
Respectful to patients		3		2
Learn for themselves	7	3	1	12
Enjoy themselves	2	2		4
Confidence	1	2	1	4
Multi-professionalism		2		3
Teamwork	1			1
Critical perspective		1	1	2
Look after own mental health		1		1

Notes

1. For details of how this table relates to attitudes nominated by the coordinators of the individual courses, see appendix 3.
2. **Coordinators of Basic Sciences/ 8 elements** refers to interviews with coordinators of:
   - Foundation term
   - 5 one term Systems Courses that ran through the 1st 2 years
   - Scientific Basis of Medicine Course in the 3rd year
   - 1st 2 years.
3. **Coordinators of Clinical courses/ 25 elements** refers to interviews with coordinators of:
   - 2 Early Patient Contact courses in the 1st 2 years
   - Clinical Foundation Course
   - 20 Clinical Attachments that ran over the 3rd, 4th and 5th year
   - 3rd year.
   - 5th year.
4. **Whole course/ 35 elements** refers to:
   - All the interviews referred to in the 1st 3 columns
   - Interview with overall medical education coordinator.

issues that can be seen as related to health promotion, such as patient centredness, teamworking and taking a critical perspective. The salient attitudes mentioned here will be returned to later in the thesis.

The verbatim statements of aims and attitudes that relate to the specific issues that will be looked at in these two findings chapters will be included in summary tables as each issue is covered.

HEALTH

- ***This thesis will examine the extent and nature of teaching about health, as opposed to illness and disease, in the medical curriculum, and staff attitudes towards the idea of health.***

Learning about health and normality as an aim

Table F3 revisits the written and orally stated aims of the curriculum listed in table F1, and has extracted from them those that appear to relate specifically to health and normality and specifically to disease. The table shows that *'understanding and dealing with disease'* was mentioned 113 times, and across 30 of the 35 elements, while *'learning about aspects of health and normality'* was mentioned 42 times, across 21 of the 35 elements. So, the importance of learning about health and normality received some clear recognition, even if it was not seen as important as learning about disease.

The types of aims included under *'health and normality'* have been fairly stringently selected to be restricted only to those clearly and overtly about health and normality. Many of the other aims not included in this list, for example, *'communication', 'public health perspectives',* and *'to have positive attitudes towards particular patients'* could be seen as also containing some very positive elements: they were certainly not concerned solely with disease.

The aims of the curriculum were thus predominantly, but by no means exclusively concerned with disease; it was clearly the intention of those who wrote the aims of the courses that they would also teach about aspects of health and normality.

Use of the term *'health'*

A word search of the interviews was carried out on the words *'health/ healthy/ unhealthy'*. The results, grouped in clusters of specialties are shown in table F4.

In the interviews, the words *'health/ healthy/ unhealthy'* were used by most staff, 36 out of

Table F3: Comparison of aims about disease with those about health [1]

Key: √ = written in medical curriculum book ☺ = said by coordinator in interview

learning..	COURSE AIMS: learning...	Basic sciences[2] 8 elemts	Clinical courses[3] 25 elemts	Year 4 proj	Whole course[4] 35 elemts
Understanding and dealing with disease	to understand disease (stated specifically)	√5 ☺ 2	√4 ☺ 3		√10 ☺ 6
	to take a history & do a physical examination		√20 ☺16		√21 ☺17
	to diagnose/ detect disease		√ 14 ☺ 9		√ 15 ☺ 10
	about the management / treatment of disease		√10 ☺ 5		√12 ☺ 6
	'clinical skills' (details unspecified)	☺ 3	√6 ☺ 5		√7 ☺ 9
	total 'understanding and dealing with disease'	**10**	**92**		**113**
	total number of elements mentioning	**6/8**	**23/25**		**30/35**
Understanding health/ normality	knowledge and understanding about the body/mind	√6 ☺ 7	√2		√10 ☺ 8
	about normality (stated specifically)		√4 ☺ 2		√ 5 ☺ 3
	about the determinants of health	√2	√6 ☺ 3		√8 ☺ 3
	about prevention	√2	√3 ☺ 2		√6 ☺ 3
	about behaviour change/ lifestyle	√1	√1 ☺ 1		√2 ☺ 1
	about sexual health		√1 ☺ 2		√1 ☺ 2
	about pregnancy/ childbirth /development	√1	√3 ☺ 2		√5 ☺ 3
	total 'understanding health/normality'	**19**	**32**		**42**
	total number of elements mentioning	**7/8**	**13/25**		**21/35**

Notes

1. Entries for this table have been extracted from table F1, which is in turn built from appendix 3 which gives details of individual course aims.
2. **Basic Sciences/ 8 elements** refers to:
   - Foundation term
   - 5 one term System Courses that ran through the 1st 2 years
   - Scientific Basis of Medicine Course in the 3rd year
   - Entry in medical curriculum book and comments by the coordinator on the aims of 1st 2 years.
3. **Clinical courses/ 25 elements** refers to:
   - 2 Early Patient Contact courses in the 1st 2 years
   - Clinical Foundation Course
   - 20 Clinical Attachments that ran over the 3rd, 4th and 5th year
   - Entry in medical curriculum book and comments by the coordinator on the aims of 3rd year.
   - Entry in medical curriculum book on the aims of 5th year.
4. **Whole course/ 35 elements** refers to:
   - All the elements of the course, i.e. totals of the 1st 3 columns
   - Entry in medical curriculum book and comments by the medical education coordinator on the aims of the course as a whole.

Table F4: use of words *'health/ healthy/ unhealthy'* in interviews

3 Overall course coordinators	Number of times words used	19
	Average usage per person using them	6.3
	Proportion of interviewees using words	3/3 (100%)
7 Basic scientists	Number of times words used	21
	Average usage per person using them	3.5
	Proportion of interviewees using words	6/7 (86%)
18 Hospital Clinicians	Number of times words used	32
	Average usage per person using them	2.6
	Proportion of interviewees using words	12/18 (66%)
5 Primary Care Specialists	Number of times words used	13
	Average usage per person using them	2.6
	Proportion of interviewees using words	5/5 (100%)
3 Psychologists	Number of times words used	16
	Average usage per person using them	5.3
	Proportion of interviewees using words	3/3 (100%)
1 Sociologist	Number of times words used	4
	Average usage per person using them	4
	Proportion of interviewees using words	1/1 (100%)
6 Public Health Specialists	Number of times words used	44
	Average usage per person using them	7.3
	Proportion of interviewees using words	6/6 (100%)
Totals	**Total number of times words used**	**149**
	Total average usage per person using them	**4.1**
	Total proportion of interviewees using the words	**36/43 (84%)**

Notes

- Instances of the use of the words that were immediate and simple repetition of the interviewer's question were not counted.
- Instances of the use of word *health* with common health service nouns e.g *health centre, child health, public health, health professional* were not counted.
- Instances of the word *health* used with *health promotion* or *health education* were not counted (they are looked at in table F6.
- Uses of the word *health* in combination to give *mental health, sexual health* and *health beliefs,* and in the phrase *Health of the Nation'* were counted.

43, or 84%, and among those people, an average number of 4.1 times per person. All the staff who were overall coordinators, and specialists in Primary Medical Care, Psychology, Sociology and Public Health used them. Clinicians, other than those in Primary Medical Care, were less likely to use these words than average, with only just over half of them using them. So, it would appear that the concept of health was a familiar one to most staff, but less on the minds of hospital based clinicians than other groups.

Teaching about health in the course in general

Table F5 attempts to summarise the state of teaching about health in the medical curriculum.

Several staff commented on how the idea of positive health, as opposed to mere normality, was treated in the curriculum as a whole. Of these, only one, the coordinator of the Clinical Foundation Course, felt that positive health was widely taught in the medical curriculum as a whole:

> *the medical school is not obsessed with disease any longer.....through the psycho-social side, there's a lot of emphasis put on counselling and promoting healthy lifestyles, and other things..., and I'm sure the students do pay attention to that.*

He reported that some staff even tell him that this kind of thing (which he summarised as *'psycho-social'*) had gone too far:

> *I mean the thing that people beat me over the head with is, I get told there's too much psycho-social... when are we going to teach them some facts?*

However, as we shall see, all the other comments made on this issue suggested that, on the whole, respondents felt that teaching about positive health was not common.

The overall coordinator of the medical curriculum commented that, among a range of issues, one of the original goals of the medical curriculum when the Medical School was founded, was to look at health as well as illness:

> *...the Todd report had highlighted a whole series of issue, particularly that medical education at undergraduate level was far too much targeted on ill health and not enough on health,... so when the medical school was set up in Southampton the original designers of the curriculum made a particular point in trying to address some of those issues.*

However, he reported that, when he became more involved recently, it had appeared to him that the goal of teaching about positive health was not being realised in the medical curriculum:

Table F5 ***'Health and normality'*** **in the medical curriculum**[1]

Course	In medical curriculum book [2]	According to staff in interview (negative instances in brackets)
Course as a whole	Aims: *- 'understanding of the ..body and ..mind in health and disease* *- pregnancy, childbirth, development...* *- principles of prevention..maintenance of health'*	(Overall coordinator and 3rd year coordinator felt not much emphasis on health) 1 coordinator thought there is now an emphasis on positive health across the course
Basic sciences		(Coordinator of first 2 years felt medicine as a whole too illness centred 2 clinical coordinators thought too much focus on disease in these preclinical courses 5 preclinical staff remarked that not much emphasis on health in these courses 4 said students not interested in health Emphasis on clinical relevance said to induce focus on disease)
Term 1: Foundation	Aim: *'understanding of normal biological structure and function'* PHM lectures on: *'Measures of health status'* *'Variations in health'*	(Coordinator felt medicine as a whole too illness centred)
Term 2: Cardio-pulmonary	Aims: *'understand factors which motivate people to adopt healthy behaviour..* *'understand normal functioning and control of cardio-vascular and respiratory systems'* Psychology lectures on: *'Cardio-vascular health'* *'Health belief model'* Sociology lectures on: *'Health inequalities'* *'Inequalities, poverty and health'* *'Ethnicity and health'* *'Gender and health'* *'Lifestyle, community and health*	(Reported emphasis on disease), but said they tried not to introduce too much or students *'get sick of it'* Said students used selves as guinea pigs e.g taking blood pressure and ECGs.
Term 3: Locomotor	Aims: *'understand..dynamic nature of locomotor system* *appreciate changes which occur in the ..system during development'* Psychology lectures: *'Child Development* (6 hours)	(Reported emphasis on disease)
Term 4: Nervous and Neuroendro-crine	Aims: *'understanding of structure, physiology, pharmacology..biology..of the nervous system'* Sociology lectures on: *'Family's role in health'* and *'Development and ageing'.*	

Term 5 Endocrine, Human Repro. and Nephrology	Aim: *'understanding of the principles by which 3 major systems... operate'* Psychology: '*Sexual health'* (4 hours lectures, 4 hours tutorials) Sociology lectures: *'An introduction to health policy in the UK'* *'The health and social care interface'*	(Some reported emphasis on disease) - Coordinator said preferred to start by discussing normality, *'more logical'*
EPC PMC		*'Great efforts made to link in positive health'*
EPC Human Repro.	Aim: *'to observe labour and delivery in the normal patient'*	Focus on '*normal healthy woman*'
Public Health	2 hours of lectures: see above under term 1	Lecture on health promotion Lecture on '*measuring health'* included work on positive health status (Otherwise, focus on disease)
Psychology	17 hours of lectures: see under terms 2, 3 and 5, above	Confirmed lecture content (One teacher thought students find *'problematising health'* difficult)
Sociology	5 lectures: see under terms 2, 4 and 5, above.	Confirmed lecture content
Clinical attach Year 3 and 4		(3rd year coordinator thought no emphasis on 'positive health' in the clinical attachments)
Child Health	Aims: *'to gain knowledge in the range of normality and be able to recognise the well child* *concepts of growth and development of well and ill children'*	Said routinely touched on normality: felt paediatrics mostly study of *'variations on normality'*
Geriatric Medicine	Aim: *'gain a balanced view of health in old age'.*	Mentioned idea of 'relative health'
O&G		Remarked that students naturally met healthy people on the attachment
PMC		Said it might come up opportunistically Mentioned idea of 'relative health'
GU		Keen that students understand and recognise the 'normal'
5th Year clinical attach		
O&G	Aims: *'understand normal labour..* *become familiar with the range of normality in obstetrics'*	
Total (from 38 elements)[3]	12	13

Notes

1. This table only notes positive instances. If a column is blank, or a course is not listed, it can be assumed that the entry would have been negative.
2. As Public Health Medicine, Psychology and Sociology did not have an entry in the medical curriculum book, their course handbooks have been used instead.
3. *'38 elements'* refers to all the categories used for this particular analysis, which were the 31 courses, the course as a whole, 1st and 2nd years together, the 3rd and 4th year together, the 5th year, and Public Health Medicine, Psychology and Sociology.

by the time I was taking part in that working party, which was 20 years after the school actually started, it had turned out to be difficult to achieve the style of medical education that was actually envisaged. There was actually an awful lot of regression to more traditional models.

Several staff intimated that this lack of interest in positive health was not an oversight, but that teaching about positive health went against the grain of the ethos of the medical school, the background of the teachers, and most of all the motivations of the students. These points of view will be examined in the sections which follow.

Health in the basic sciences

Several staff commented on the teaching about health, in the sense of 'normality', usually suggesting that such teaching was not happening to any great extent, and often putting forward reasons why this might be so.

The coordinator of the first and second years pointed out that teaching about disease and illness came naturally to the many of the staff who ran the courses, who had themselves been educated within such a perspective:

a pathologist is looking at disease by virtue of their specialty.....Bio-chemistry is looking at the abnormal by definition.

He made a further significant point that many students did not find the concept of health attractive, being much more drawn towards disease, *'cos that's why they're all here'* as he put it, adding:

for many of them the attractiveness of curing disease is much greater ..and, lets face it, that is where the money is still in the profession, rather than the promoting good health and the prevention mechanisms.

3 staff agreed that the students were uninterested in studying health and/or the normal, which they were said to dismiss as *'boring anatomy'* according to the coordinator of term 3, the Locomotor Systems course. As the coordinator of term four, the Nervous and Neuroendrocrine Systems course put it, *'students want patients'* and added: *'even if there was an accent on health I don't think many of the students would pick it up.'* She felt that *'medics always need as driver a pathological case to spark some interest'*, a point reiterated by a the third year coordinator, commenting on the basic science courses:

If you give them a clinical case history of heart failure, they're dead interested, much better than just giving them a lecture on the normal anatomy of the heart and the normal physiology...

A teacher of Psychology, who had herself had considerable involvement in nursing education, felt that the problem of a lack of student interest in health was common across all the health related professions, *'what drives people to go into medicine and nursing and other professional groups is because they are actually quite interested in pathology'*. She said that those teaching nursing were tussling with the same issue:

> *they tried it in nursing, of actually sending people out and spending the first year thinking about health, but that's not why nurses want to be, they want to be a bed side hand on the fevered brow.*

She felt that in any case, students in their first two years were too young to understand why the idea of health was important, and that it should thus be left until later in the course:

> *it actually takes quite a lot of maturity to problematise health....*
> *I think you need to actually look at all your gory pictures and think about all the diseases, because that is what you are really interested in, and then to actually say "hang on a minute you know actually what is health?", and so I think we should actually get there in the fifth year.*

We have already noted the central value placed on integration by the medical school, especially efforts to blur the traditional 'preclinical/ clinical divide'. According to some staff, this desire to integrate lead to an emphasis on the pathological. Many clinical teachers were still critical of the preclinical teaching, which they saw as still 'too theoretical' and not sufficiently 'relevant' to clinical practice. So basic science staff reported that they felt under pressure to make their courses 'more clinically relevant', and they tended to interpret 'clinical relevance' as teaching about disease and illness. As the coordinator of term 2, the Cardio-Pulmonary Systems courses said:

> *When I took a session on respiratory function I taught them about having patients and how the signs and symptoms will change etc. Admittedly it's a fairly basic level, but none the less it's all done with a very clinical slant.*

Staff reported that all the basic science courses had a strong emphasis on pathology and disease. For example, the coordinator of term 3, the Locomotor Systems course reported that the course used 'fracture' as a way of teaching basic anatomy of the limbs, while the coordinator of term five, the Endrocrinology, Human Reproduction and Nephrology Systems course, mentioned teaching about 'miscarriages' to explain human reproduction.

However two basic science course coordinators were not so sure that this emphasis on disease struck the right balance. The same coordinator who was quoted above talking about how he introduced patients' *'signs and symptoms'* into his term 2, the Cardio-Pulmonary Systems course, went on immediately to say that care had to be taken not to introduce too much *'clinically relevant'* material before the students were ready for it, or *'they get sick of*

it.' He said that they also tried to teach *'the normal'* by using the students themselves as guinea pigs, *'we do lots of practicals where they measure their own blood pressures, measure their own respiratory function.'* The coordinator of term five, the Endocrinology, Human Reproduction and Nephrology systems course felt even more strongly that students need a good grounding in understanding and recognising the normal before they were ready to look at the pathological. He said he took such a positive line in his own teaching:

> *it just seems logical to me, for example, if you have a car it is better to know how it works before you start looking at it when it has gone wrong.....Some people do use the clinical situation to emphasise the basic science, but I find it much more logical to start with how things normally work, and then what can go wrong.*

He claimed the students liked this approach better, agreeing with his opinion that it was *'more logical.'*

Ironically it was the two Early Patient Contact courses which gave the students the patients they were said to want, which apparently also most strongly emphasised the idea of normality. The coordinator of Early Patient Contact, Human Reproduction, talked of the importance of the contact this course gave students with a normal woman through childbirth and its aftermath, *'perhaps the first time they might have seen, in the flesh a woman having a normal delivery'*. The Chair of the Primary Medical Care group, when questioned in general about the idea of positive health, singled out Early Patient Contact Primary Medical Care as being the place, *'where great efforts were made to try and link that in'.*

Although most of the preclinical staff seemed to think that the clinical courses wanted them to concentrate on disease and illness, two coordinators of the clinical attachments of the third and fourth year claimed not to want such an emphasis, and felt that the preclinical courses should put more emphasis on normality, which would provide a better grounding for their own attachments. The coordinator of Child Health, who as we shall see placed a good deal of emphasis on normality in his third year attachment, said:

> (understanding the) *range of normality, ..is a major issue for us, and I would like to see that being in the first two years and it isn't.....to get more of a concept of change over time, and the velocity of change in the normal child, in order to then superimpose on that the understanding of how things go wrong...*

He suggested that it would be a useful experience for the students to have ongoing contact with a normal baby through Early Patient Contact in the first two years:

> *when they come to the third year they would have seen a baby through to a two year old, which is where the most rapid changes are occurring, and it would give them much more of a concept of what we are trying to get at.*

Similarly, the coordinator of the ENT attachment lamented the decline of traditional teaching about structure and function in the first two years, and felt that the concentration on what he saw as 'student pleasing' issues of immediate interest meant students no longer came to the attachments with the kind of background understanding of normality that enabled them to appreciate abnormal signs and symptoms:

> *I think we have moved too far away from teaching structure and function....very often the abnormal bit that one is looking at is significant only to an eye of somebody who is used to looking at the normal.*

Health in Public Health Medicine

At least one member of the Public Health Medicine group, a specialist in health promotion, taught students about positive health in her lecture on *'health promotion'*, and she and another member of staff, the Chair of the group, had complex concepts of health expressed in relation to their interest in health promotion: their views will be discussed a little later, in the section under that name. One other teacher from the group reported that he also tried to teach students about measures of *'positive health status'*, but that they seemed rather bemused by this:

> *I talk to them a bit about measures of health status as a means of measuring health, and I always say that "Here we are talking not just about measures of disease, but measures of positive health", but I'm not really sure they understand what I am talking about.*

Apart from these inputs, Public Health Medicine seemed to concentrate on disease epidemiology, which they claimed to regard as their central goal, rather than on aspects of health. When asked whether anything was likely to come across to students about *'positive health'*, outside of the one designated lecture on *'health promotion'*, the teaching coordinator of Public Health Medicine replied *'no, nothing I can think of'*.

Health in the psycho-social sciences

As table F5 suggests, the psycho-social sciences made some contribution to the study of health, in the sense of looking at its social and psychological aspects. We have already looked at the comments made by a teacher of Psychology, who thought that undergraduate medical students found the problematising of the idea of health difficult and uninteresting. There were few other oral comments on the teaching of health specifically. There were however several mentions of health in the course outlines, and staff from both Psychology and Sociology confirmed in interview that the course outlines formed an accurate overview of what they taught.

As table F5 shows, according to the outline of the course they produced, the Sociology

group delivered 23 lectures in the first two years. In term two the work of the group was described as being concerned with *'social dimensions'* of health, and all 5 lectures had the word *'health'* in their titles, namely: *'health inequalities'; 'inequalities, poverty and health; 'ethnicity and health'; 'gender and health';* and *'lifestyle, community and health'.* The group's input in term four consisted of 4 lectures about aspects of *'the family'*, including one on *'family's role in health'* and two on *'development and ageing'.* (The other 12 lectures across the first two years were about: aspects of the health service (6); the roles and relationship of doctors (2); illness and stigma (2); non orthodox therapies (1); and the nature of Sociology as a discipline (1).) So it would appear that at least half the input of the Sociology group was concerned with health and normality.

The outline produced by the Psychology group counted their contributions in terms of contact hours in lectures and practicals. Of the 22 hours they taught, 17 appeared to be on health and normality, the relevant topics covered being *'sexual health* (8 hours); *'child development'* (6 hours); *'cardio-vascular health* (1 hour); *'health belief model'* (1 hour); and *'smoking health education material'* (1 hour). (The other inputs were *'symptoms and their meaning'* (2 hours); *'pain'* (2 hours); and *'black schizophrenia'* (1 hour).)

So it would appear that both of the psycho-social sciences spent a large proportion of their time teaching about aspects of health.

Health in the clinical attachments

We have seen in table F4 that hospital clinicians, were less likely to use the words *'health/ healthy/ unhealthy'* than were other groups. Table F1 showed that the clinical attachments in general (both hospital and Primary Medical Care) mentioned aims connected with 'health and normality' 32 times and across about half of the courses, 13 of the 25, in contrast to basic science courses which mentioned them 19 times and across almost all, 7 of the 8, courses. This would suggest that the idea of health and normality was less familiar to clinicians than to other groups.

The impression of the overall coordinator of the third year was that in practice the third year attachments did not look at positive health *'in the sense of like healthy people, no'.* As we shall see, her assessment proved to be broadly true, but with some small scale exceptions.

According to their coordinators, normality was routinely touched on in two attachments, namely Genito-Urinary and Child Health. The coordinator of the Genito-Urinary attachment, said:

> *we want them to be able to understand the importance of knowing what normal and abnormal looks like. But certainly what normal looks like.*

Similarly the coordinator of the Child Health attachment, who we have already seen was keen that the first two years do more to fix the idea of normality in students' minds, remarked that in his course they taught students that what paediatricians often see were '*variations of normality*', which may be worrying parents, but were not actually diseases:

> *It might be a problem, a problem for the parents, but nevertheless one of the most important diagnoses one makes is normality, and that comes out quite frequently.*

The entry in the medical curriculum book for the Child Health attachment confirmed the coordinator's claim, as including among the aims:

> *to gain knowledge in the range of normality; to be able to recognise the well child; to introduce students to the concepts of growth and development in both well and ill children.*

It appeared that two other attachments, namely Obstetrics and Gynaecology and Primary Medical Care, considered issues to do with health and normality, albeit while having their main focus on disease. The coordinator of Obstetrics and Gynaecology remarked that this attachment was one in which students naturally met healthy people. He taught students that the fact obstetric patients were not ill makes a difference to how they need to be treated:

> *there is a different relationship between an obstetric patient and antenatal patient than somebody with a disease, and you don't have the same right of doctor/patient relationship that there is in other contexts.*

He suggested however that the main emphasis in Obstetrics and Gynaecology in the context of the hospital was nevertheless on disease. He said that doctors such as himself still preferred the pathogenic term '*patients*' to more salutogenic ones, *'midwives call them "clients" rather than "patients", which we still resist'*. He said the attachment had '*a focus on specific disease'*, adding:

> *I wouldn't say we had a kind of 'well women' approach, which I think probably wouldn't be that appropriate within the context of a hospital based speciality, probably more appropriate in Primary Care.*

The Chair of the Primary Medical Care group felt that work on positive health in the third year Primary Medical Care attachment would be, *'very patchy, not as far as I know, systematic'*. She said they did not teach about how students could positively look after their own health:

> *we don't have any systematic things about how to look after their health, rather than them saying "Oh God I think I have got this!"*

Another third year Primary Medical Care teacher felt that her seminar students might or might not get a view of positive health, depending on what came up opportunistically that year, but said that it was not something she viewed as essential:

> *I hope they would get a wider view, but I don't think that always happens. It does depend very much on what comes up and the way in which discussions go, it is not something that I would impose I don't think.*

The two coordinators of the third and fifth year Psychiatry attachments both felt that their specialty over emphasised disease and illness, and they expressed keenness to develop a more positive approach. They were particularly conscious of the 'mental health - mental illness' debate, which they discussed with apparent interest and no prompting. The fifth year Psychiatry coordinator talked at length of the irony of using the name 'mental health' for what he saw as essentially an illness service:

> *this sort of double-speak does get problematic I think, and it is very hard when you get labelled as a 'mental health' service, because we are not, we are a 'mental illness' service. It is tempting sometimes to pick up the phone and say "No sorry, mental health? You have got the wrong department, we only deal with ill people here."*

Commenting on the teaching of Psychiatry in the third year attachment, the coordinator said that '*there is not a lot on mental health....it would be nice to develop that*'. The fifth year coordinator also felt that the balance of the teaching was wrong, and said that the hospital based nature of their teaching meant that students received little experience of wellness, '*because they are based in clinical services, they are really not coming into contact very much with well people*'. He felt that there was too much emphasis on the specialised teaching of exceptional and severe pathology, *'at the moment we teach Psychiatry too much as the speciality of Psychiatry and not the Psychiatry that all doctors need to know*'. He felt that students were meeting '*the most severe mental illness, in-patients, patients with chronic schizophrenia*', when in later practice the kind of patients they would meet would be:

> *patients with substance misuse, deliberate self harm, depression, the sort of milder but much more common disorders.*

So, there were some suggestions that some of the clinical attachments concerned themselves with health and normality but, outside of these rather infrequent statements, there were no further indications that the idea health and normality was taught or considered in any of the clinical attachments. However, staff from one specialty, Psychiatry, would have like to have seen more emphasis on wellness, normality and fairly common psychiatric conditions, and less on illness and rarer conditions.

The status of health in medicine as a whole

Four staff, when asked about health in the medical curriculum, were keen to place the discussion in the wider context of the status of health in medicine in general. This was a subject on which they talked at some length, and unprompted.

The coordinator of Palliative Care felt that medicine spent far too much money on incurable sickness:

> *if we are spending something like.... 10 billion plus on people in their last year of life, there must be an awful lot of salvageable money because we are treating people who don't get better.*

Two other staff agreed that the neglect of health by medicine was a problem, and that it had deep roots. The coordinator of the first two years agreed that medicine '*is still about illness and disease and curing*', and felt that changing this would need a major change in funding policy, which in turn would need a major political shift:

> *while you have got an NHS system that is funded to cure people, that is the market force..It is shifting but I think it would actually require a much more radical change at a national level. Perhaps more needs to be done that way to fund not illness, but to fund health. But for that a major political national change that is needed, and we cannot go against the main stream.*

A Public Health Medicine lecturer thought the problem very deep seated indeed, as he thought that a concern with positive health had, historically, never been the province of the doctor:

> *...that Thomas McEwan book on the role of medicine, he is absolutely right in everything he wrote in that book about the fact that doctors haven't really contributed much to health. Where he had made a flaw is he assumed that is what doctors are for, and doctors have never been about that I don't think, that's not what medicine has ever been about.....*

It was not clear whether he regretted this or not.

So, those four staff who commented on the issue, felt that medicine was not much interested in understanding positive health, and that the problem was a fundamental one.

The concept of 'relative health'

We have seen that the clinical attachments were not particularly concerned with absolute wellness or health. However, three of them did indeed appear to be working with an explicit notion that could be termed 'relative health', a notion of patients getting along as normally as they could, acknowledging their disease, and being in a sense 'well' despite rather than because of their physical health status.

For example, when asked about positive health, the Chair of Primary Medical Care felt that Early Patient Contact contained, *'discussions about how people live well, despite disease, that idea of positive health.'* Similarly the third year Primary Medical Care coordinator said:

> *I think, learning that it wasn't a case of gall stones in bed three, that it was Mrs So-and-So who has a job, who has a husband, who has children and runs whatever she does, you know, and has a life outside her gallstones.*

This idea of 'relative health' appeared to be shared by two other specialties. The entry in the medical curriculum booklet for the Geriatric attachment said that it aimed that, *'students will gain a balanced view of health needs in old age'*, which, from the comments of the coordinator appeared to mean 'as well as can be expected'. He was under no illusions but that old age is a period of physical decline, *'I think you start with the premise that biologically ageing is, in biological terms, bad news'*. However he said they taught students that disease and related problems were not necessarily central to the patient's experience, and should thus not necessarily concern the geriatrician, *'if it doesn't bother the patient what is wrong with them, it doesn't necessarily bother me.'* The attachment was said to emphasise the positive side of old age, for example, looking at the way in which the elderly cope proactively with the challenges that face them:

> *if you get to 83 you have lost a lot of things: you don't work anymore; you have lost lots of roles; you may well not be very rich; lots of people have died; and yet most people actually aren't depressed, and they have strategies for dealing with this, and coming to terms with their life, and having meaning in it.....*

Indeed, in talking about the aims of the attachment he felt that the main goal of the course was to convey positive attitudes about the elderly:

> *people who you are looking after have had rich and varied lives, because they have had long lives, so that they are actually interesting people to talk to..*

Similarly the coordinator of the Palliative Care attachment also felt that his course aimed to emphasise the positive, despite the potentially grim nature of the subject matter. He talked of how frightened many students were of coming to the attachment, and how one of the goals of the course was to put cancer in perspective, and help students feel that there was something positive they could do for patients:

> *the most important thing is to actually is to walk away and think that cancer is not the end of the world....there is an awful lot of good practical and psychological, emotional things you can do to help people and families.*

So, although positive health was not much discussed in the clinical attachments, a concept

that could be termed 'relative health' was made explicit in at least three of them.

Summary of health

'*Health*' was a term that was used fairly frequently in the interviews, and by most staff. Analysis of the written and oral aims of the courses suggested that the medical curriculum, and particularly the basic science courses, strongly intended to teach students about health and normality as well as disease and illness. However, it appeared that this intention was not so often realised in practice. Although scattered examples of teaching about normality were reported as occurring in both the preclinical and clinical courses, the overwhelming emphasis appeared to be teaching about illness and disease.

In the preclinical courses, the educational backgrounds of the teaching staff, the motivations of the students, and the wish of the medical school to blur the distinction between preclinical and clinical studies were all suggested as leading to a concentration on the pathological. This was a tendency which a few clinical coordinators said they found unhelpful to their specialty, where an understanding of the normal was seen as an essential touchstone against which to measure the abnormal.

Teaching about positive health proved to be even less common than was teaching about normality, and confined to the psycho-social sciences, which contained some discussion of the social and psychological nature of health, and to Public Health Medicine, which taught a little on health promotion and measures of positive health (although the emphasis in this specialty was said to be mainly on the epidemiology of disease).

A few staff commented that this lack of interest in health, and focus on illness and disease, went right to the roots and funding of medicine itself: it was an ethos which most of these staff regretted, but which one seemed to see as inevitable.

However, a concept that could be called 'relative health' was perceptible in some of the clinical attachments, in Primary Medical Care, Geriatric Medicine and Palliative Care, where coordinators reported that they encouraged students to take a positive approach to patients, and realise that it was possible for patients to be in some sense 'well', especially psychologically, despite their disease.

HEALTH PROMOTION

The next section will consider two objectives:

- ***This thesis will look at where 'health promotion' and/or 'health education' were taught under those names in the medical curriculum, what was included under those titles, what staff understood by the terms, and what attitudes they had towards them.***

- ***This thesis will investigate whether staff distinguished between the terms 'health education' and 'health promotion' and if so, what was the nature of the distinction they made.***

Table F1 showed that *'health promotion'* itself was not cited as a formal written or oral aim in the medical curriculum, using that particular term. Nevertheless, the words were used in interviews and in course documentation, and although it is a central argument of this thesis that health promotion is, on the whole, best sought in other guises in medical education, it is also important to look first at where it made an appearance under its own name.

Use of the terms *'health promotion'* and *'health education'*

A word count was carried out on the use of the words *'health promotion'*, *'promoting health'* and *'health education'*, and is summarised in table F6. It shows that the words appeared to have some meaning for staff.

'Health promotion' as a term was used by almost half of the staff, and, among those using it, 4.1 times each on average. It seemed most familiar to the overall course coordinators and those in Public Health Medicine, all of whom used it. As with words connected with *'health'*, these words seemed less familiar to hospital based clinicians, with only a quarter using them. Slightly fewer staff used the term *'health education'*, and among those who used it, it was used 2.3 times each on average, although in this case hospital based clinicians use of them was average.

So although *'health promotion'* and *'health education'* did not appear to be terms with wide currency in the medical curriculum, they were in use across all groups.

Table F6: use of words *'health promotion/ promoting health'* and *'health education'*

Group		*health promotion*	*health education*
3 Overall course coordinators	Number of times words used	13	4
	Average usage per person using them	4.3	4
	Proportion of interviewees using words	3/3 (100%)	1/3 (33%)
7 Basic scientists	Number of times words used	6	4
	Average usage per person using them	2	4
	Proportion of interviewees using words	3/7 (43%)	1/7 (14%)
18 Hospital Clinicians	Number of times words used	11	19
	Average usage per person using them	2.75	2.4
	Proportion of interviewees using words	4/18 (22%)	8/18 (44%)
5 Primary Care Specialists	Number of times words used	14	5
	Average usage per person using them	14	1.6
	Proportion of interviewees using words	2/5 40%)	3/5 (60%)
3 Psychologists	Number of times words used	6	1
	Average usage per person using them	3	1
	Proportion of interviewees using words	2/3 (66%)	1/3 (33%)
1 Sociologist	Number of times words used	1	2
	Average usage per person using them	1	2
	Proportion of interviewees using words	1/1 (100%)	1/1 (100%)
6 Public Health Specialists	Number of times words used	36	8
	Average usage per person using them	6	2.6
	Proportion of interviewees using words	6/6 (100%)	3/6 (50%)
Totals	**Total number of times words used**	**87**	**43**
	Total average usage per person using them	**4.1**	**2.3**
	Total proportion of interviewees using the words	**21/43 (48%)**	**18/43 (42%)**

Notes

- Instances of the use of the key words that were immediate and simple repetition of the interviewer's question were not counted.
- The use of the word *'education'* on its own when it was, from the context, clearly related to patients, not students, was included under *'health education'*.

CONCEPTS OF HEALTH PROMOTION

How the concepts were derived

Table F7 summarises the concepts of health promotion that were expressed by staff in interview.

It is important to note that this table only lists concepts that were mentioned explicitly by respondents in relation to *'health promotion'* and *'health education'*, either as a direct response to the interviewer's question and/or by the respondent using these terms themselves. Many staff did in fact employ some of the concepts that appear in these tables elsewhere in the interview, but not explicitly in relation to the terms *'health promotion'* and/or *'health education'*. So the lack of an entry by a concept should not be taken to mean that it was not discussed at all, and many of the issues and concepts will be returned to later in this chapter in other contexts.

Who expressed concepts of health promotion

Before we look at the concepts individually, it is worth making a few comments on who it was who contributed to this discussion, and how they connected the concepts together.

It is notable how few staff contributed to most of the concepts of health promotion outlined in table F7. Despite being asked direct questions about *'health promotion'*, 26 of the 46 staff interviewed did not comment on health promotion at all, while for most of those that did, their comments were few and far between, and made very much in passing. Of the 27 separate concepts expressed, 24 were expressed by 6 or fewer people, and 15 concepts were expressed by three or less staff. Given that one member of staff expressed 23 of the concepts, and one other 16, it will be appreciated that most of the concepts were expressed by a very small number of people. It could be concluded that most staff did not, on the whole, spend much time or effort thinking about health promotion.

The two people who contributed most to the concepts of health promotion clearly had distinct and complex concepts of it. One of these people was the Chair of Public Health Medicine. For example, when describing what he understood by health promotion, he gave a coherent, thought through rationale for separating it into five factors, social structural, political, attitudinal, behaviour change, and epidemiological or risk factors. The other member of staff with complex concepts of health promotion was the specialist senior lecturer in health promotion, who worked in Public Health Medicine, and was a respected academic, researcher and writer in the field of health promotion. She was also a practitioner, having previously been director of a health promotion service. As we shall see, she had a great deal to say about health promotion, mostly in relation to the specific lecture she gave on it.

Table F7: Concepts of *'health promotion'* and *'health education'*, under those names, expressed by staff in interview

Health Promotion is about.....		**No.of staff** 46 in all	**Who staff were**
Prevention	Prevention	30	All staff who commented on health promotion
	Giving lifestyle advice	29	29 of the 30 staff who commented on health promotion
	Specific health related topics	6	4 topics mentioned by 6 staff: • Smoking: Specialist in HP, 3rd year coordinator, Sociology coordinator, Psychology coordinator, teacher of PMC. • Nutrition: coordinator of Locomotor Systems course • Exercise: coordinator of Locomotor Systems course • Alcohol: 3rd year coordinator
	Risk factors	3	Chair in PHM Psychology coordinator Coordinator of term 5 Endrocrinology course: risk factors for diabetes
Theory	Seeing health promotion and health education as the same	10	Coordinator of the 1st 2 years/ Foundation term Coordinator of term 6: Gastrointestinal and Lymporeticular Systems Child Health Coordinator Teaching coordinator of PMC PMC teacher Coordinator of EPC Human Reproducation and Year 5 Obs. and Gynae (same person) Coordinator of Palliative Care attachment 3 staff from PHM
	Seeing health promotion and health education as different	3	Specialist lecturer in HP Chair in PHM Sociology coordinator
	Using a range of models/ having a theoretical base	4	Specialist lecturer in HP Chair in PHM Sociology coordinator Psychology coordinator
	Positive health, not disease	6	Specialist lecturer in HP Chair in PHM Coordinator of the 1st 2 years/ Foundation term Coordinator of term 3 Locomotor systems Psychology coordinator 3rd year coordinator
	Just commonsense/ putting borrowed ideas together into a framework	1	Teacher of PHM

Social issues	Social influences	5	Specialist lecturer in HP Chair in PHM Psychology coordinator Sociology coordinator Sociology course outline
	Tackling inequalities in health	3	Specialist lecturer in HP Chair in PHM Psychology coordinator
	Improving the nation's health	3	Specialist lecturer in HP Chair in PHM Coordinator of 1st 2 years/ Foundation term coordinator
	Avoiding 'victim blaming'	2	Specialist lecturer in HP Psychology coordinator
	Creating healthy environments	2	Specialist lecturer in HP Chair in PHM
	Political influences	2	Specialist lecturer in HP Chair in PHM
	Community interventions	1	Specialist lecturer in HP
Psychological issues	Psychological influences	3	Specialist lecturer in HP Chair in PHM Psychology coordinator
	Behaviour change	4	Specialist lecturer in HP Chair in PHM 2 in PMC
	Realising there is more to behaviour change than 'telling people what to do'	2	Specialist lecturer in HP Chair in PHM
	Patient Centredness	1	Specialist in HP
	Empowering patients	1	Specialist in HP
Role of doctor	Seeing doctors as having a role to play in creating healthy environments	2	Specialist lecturer in HP Chair in PHM
	Seeing doctors as role models for health/ students looking after own health	2	Specialist lecturer in HP Psychology coordinator

Role of doctor (cont)	Seeing the role of the doctor in HP as a limited one	2	Specialist lecturer in HP Teacher in PHM
Primary care	Government targets for HP in PMC	5	Specialist lecturer in HP Psychology coordinator Teacher of PMC 2 in PHM
	Seeing HP as a job for the GP	5	Specialist lecturer in HP Teacher in PHM 3 from PMC (although all had reservations about it)
Other	Preparing sources of information/ materials	1	Psychology coordinator

It is also notable that the psycho-social science coordinators contributed to many of the concepts, and indeed all appeared to be positive about health promotion and fairly knowledgeable about its concerns.

'Health promotion as prevention'

All 30 staff who commented on health promotion appeared to connect it with the idea of prevention, and overwhelmingly with the concept of giving lifestyle advice. Indeed these were the only concepts expressed by the majority of those who expressed one at all. That they had this concept was deduced from the fact that, in speaking, most staff who used the term *'health promotion'* themselves used it synonymously with *'prevention'*, and with *'giving lifestyle advice'*, and when asked about '*health promotion'* or '*health education*', most staff answered in terms of '*prevention*' or '*lifestyle advice*', or in some cases vice versa.

For example, when asked what *'health promotion*' was covered in the course, the coordinator of the fourth year Genito-Urinary attachment replied:

> *oh yes, we are here to prevent complications, and we emphasise that to the student, the only point in treating this range of diseases is to prevent the complications, and how do you do that? You go through... you treat the patient before the complications set in, secondary prevention.*

Similarly, to the same question about *'health promotion'*, the overall coordinator of the medical curriculum replied:

> *I would like to think that all clinical attachments have elements of health promotion..you're aware of the kind of things that are going on to try and encourage people to adopt healthy lifestyles; that is an aspect of health promotion obviously.*

One of the teachers from Primary Medical Care summed up this interchangeability of terms, when she answered the question about health promotion with the words, *'as a subject, it isn't called that, but they* (i.e. the other GP teachers) *do do bits about that'*.

Six people saw health promotion as connected with specific preventive topics. *'Smoking'* was mentioned by 5 people: for example, the coordinator of Sociology said he talked about the work of Hilary Graham in his first term lectures. One of these 5 also mentioned *'alcohol'*, while one other person mentioned *'nutrition'*.

Three people connected health promotion with work on particular *'risk factors'*: for example the coordinator of term five, the Endrocrinology Systems course talked of the risk

factors in diabetes, *'the sort of danger signs: you keep your weight down and keep fairly fit and so on'.*

'The theory of health promotion'

For 10 staff, including 4 from Public Health Medicine, health promotion and health education appeared to be the same: this was deduced from the fact that they used the terms interchangeably without apparently noticing the shift. For example, when the author attempted to ask the coordinator of Early Patient Contact, Human Reproduction whether students would learn anything about *'health education for patients'*, he replied, *'its a kind of health promotion, I suppose, live healthily, don't eat fat'.* These 10 staff could therefore be said to be operating with an implicit theory that health promotion and health education were the same.

Just three staff explicitly stated that they viewed health promotion and health education as different. For two of them, the specialist in health promotion and the Chair of Public Health Medicine, the difference was in the social focus of health promotion, compared with the individualistic focus of health education. For example, the Chair talked at length of what he saw as the essential difference, with health promotion as being concerned with creating healthy environments:

> *I do think it's important that medical students are alerted to the fact that health promotion is not health education, and that they understand that what we are talking about is creating an environment in which it is easier to be healthy and to live a healthy lifestyle and so on, so it has to include social structural things and behavioural things and so on... one ought to appreciate that and that maybe tackling, unemployment, poverty, housing and all those things, might be just as important.*

The Sociology coordinator simply commented on the fact that there was a difference, saying:

> *there is a debate about exactly what constitutes health education and health promotion anyway isn't there? I think all that's quite interesting actually.*

Four staff talked positively of what they called *'theories'* in health promotion. For example, the specialist in health promotion gave as the first goal she nominated for her teaching:

> *to give a flickering of understanding that there was a theoretical basis behind this...trying to wake them up to the fact that there was a richer sort of discipline underneath this.*

All 4 of the staff who talked about theory mentioned *'models'* in health promotion, for example a teacher of Psychology talked of *'models'* in connection with smoking:

in terms of health education....because it was a smoking practical we looked at different sources of information that were presented and at some kind of different theoretical models that underpin the 'Nicorette' adverts, and those that were produced by other people....

In contrast, one teacher of Public Health Medicine was somewhat dismissive of health promotion theory, which he saw as consisting of ideas rearranged from other disciplines, *'some of it is a bit commonsense; it's just putting it together in some conceptional framework'.*

Six staff, three of them from outside of Public Health Medicine and the psycho-social sciences, distinguished *'health promotion'* from the *'prevention of disease'* as having a more positive slant. For example, the third year coordinator, referred to it as *'health promotion, in the sense of like healthy people'*, and another, the coordinator of the term three, the Locomotor systems course said they taught about diet on his course '*but not specifically tied in to disease, more in to promoting health.*'

'Health promotion and social issues'

Six staff indicated that health promotion was more than individual behaviour change, and talked about it in connection with what they tended to refer to as *'social issues'.*

Three of these staff saw health promotion as aiming at *'improving the nation's health'.* For example, the coordinator of the first two years and the Foundation term said:

I think one can make the students aware and by a number of different mechanisms at different times, that they ought to be considering, "well what can be done to improve the health of the nation?", and things like that.

Five of these staff said that they saw health promotion as connected with the study of *'social influences'* and/or '*social factors'*. For example, one of the teachers of Psychology said:

we try to get them to think about medicine as more than about curing disease, which is of course a government kind of philosophy, to actually saying "How can we go beyond that and look at identification of risk? What are larger social factors?" and the Black report and all those sort of things, and to get away from victim blaming.

The *'avoidance of victim blaming'* as a part of health promotion was a theme picked up by one other member of staff, the specialist in health promotion. She said she was keen to teach such an attitude to students:

even if they hadn't done anything more positive towards helping promote people's health, I would be quite happy, because it would have removed a

negative influence.

Three staff saw health promotion as connected with tackling issues around *'inequalities'* in health, such as *'unemployment, poverty, housing and all those things'*, as the Chair of Public Health Medicine put it:

Two staff, the Chair of Public Health Medicine and the specialist in health promotion mentioned the central importance of *'healthy environments'*, as the Chair put it, *'creating an environment in which it is easier to be healthy and to live a healthy lifestyle'*. Both also talked of the importance of political influences on health, the Chair giving as an example the (then Conservative) government's ambivalent attitude to smoking:

> *smoking...is a very important part of the economy, the government for very good reasons that they see, don't want to ban advertising because of losing a pile of revenue and that would have all sorts of detrimental effects.*

One person, the specialist in health promotion, mentioned the importance of community interventions in relation to health promotion: in describing her teaching she said she covered:

> *some of the major studies to show them that sort of community wide interventions could be researched..I think I even rattled through a bit of Oxcheck so they'd think it was relevant.*

'Health promotion and psychological issues'

Six staff connected health promotion with psychological issues.

Four mentioned theories of behavioural change, which the Chair of Public Health Medicine characterised as *'behavioural change models and readiness for change and all that stuff or whatever is the theory of the day'*. Two people felt that health promotion was about teaching students that there is more to behaviour change than *'telling people what to do'*. For example the specialist in health promotion felt that students were liable, through having had what she called *'health education'* at school, to think that telling people what to do is effective. In contrast, she tried to suggest in her lecture that it was not that easy, *'people don't do what you tell you tell them to.'* She was concerned that other medical teachers might give the students the impression that life was that simple:

> *it worries me to some extent that if you are dealing with the very medical aspects of cancer or something it is too easy those specialists to be saying, "Well of course, all this is jolly preventable you know and if only people would stop this and do that and do the other" which isn't the approach we wish to take and I suspect that does go on.*

This view was echoed by the Chair of Public Health Medicine, who said:

> *it's not just about doctors telling people what they ought to do in order to be healthy, which is the instinctive way at medical school, and most doctors at the moment still see it like that.*

The specialist in health promotion thought that in the past most doctors would have used what she called a *'medical model'* of health promotion, but that they were slowly coming to accept a more psychological model:

> *most of the big studies in Primary Care have slowly moved away from that model* (i.e. the medical model) *but only recently and still with some suspicion. But I think certain GPs realise there is a bit of science in Psychology now and it might just be respectable enough to think about.*

She was the only person to connect health promotion with the concept of *'patient centredness'*: she saw it as an essential part of health promotion that doctors exhibit *'patient centred'* attitudes in their everyday encounters with patients:

> *they can deliver sensitive patient-centred counselling one to one, and they can ensure their systems provide adequate information, they can ensure their systems, again particularly in a Primary Care context, are responsive to people as individuals.*

She was also the only person to mention *'empowerment'* in connection with health promotion (the word was used one other time in interviews, by a Primary Medical Care teacher, in relation to patient centredness, as we shall see). She remarked that empowerment models of health promotion tend to be foreign to doctors:

> *they* (i.e. doctors) *see it* (i.e. health promotion) *as telling people what to do and they don't want to do that, and they don't have the kind of models and context that you and I have got of it as empowering.*

'The role of the doctor in health promotion'

Four people talked about the role of the doctor in health promotion.

Only two people talked about a positive role for doctors: they were the specialist in health promotion and the Chair of Public Health Medicine who both saw the doctor as having a role in agitating for a healthy environment. As the specialist described it, when talking of what she hoped students would learn:

> *the other main thing is for them to realise that not only are there other influences, but they might have some sort of role in working in those other spheres. Students could be agitating for things, cycle ways or something, as individuals they can do something, or they can work with other people in the*

longer term.

She outlined a complex agenda for doctors, which encompassed a role in formulating healthy policy:

> *in terms of, say, health promoting hospitals, if they are not on board and don't start thinking prevention then you'll just get treatment going on, and as we all know, GPs run the NHS these days.*

However, this specialist in health promotion seemed rather ambivalent about the role of the doctor, being one of two staff who also said that they saw the role of the doctor in health promotion as limited. She seemed at one point in the interview to become quite dismissive of the kind of active roles in health promotion that she had previously been advocating, preferring the 'skilled technician' role, *'I think I'd rather be sure that the doctors were being trained to fix me up when I really needed it.'* She expressed the view that doctors were, *'a tiny part of the health promotion picture'*. She felt that there were others, such as, *'managers of local leisure centres or environmental health officers who are having perhaps more of an impact'*. She was not sure that doctors have that much influence or were held in that much reverence by the population anyway.

One of the lecturers in Public Health Medicine, himself a medical doctor, also talked of the limitations of the role of the doctor in this field when asked specifically about health promotion. He said he felt that their 'Public Health Medicine' group should drop the last word, and wondered whether doctors had a role in public health it at all:

> *whether there is any role for doctors in Public Health, let alone doctors having the monopoly of the so called Faculty, I don't know.*

Two staff, the specialist and a teacher of Psychology, saw health promotion in medicine as being concerned with the importance of doctors as 'role models'. The specialist said she attempted to suggest to students the various roles that health professionals can play in health promotion, including role modelling *'by the way they lead, and the behaviours they model'*.

'Health promotion and Primary Medical Care'

Three staff from Primary Medical Care expressed the view that health promotion was a task for the GP, although they and others in this group also expressed some reservations about this role, in terms of the effectiveness of health promotion, work overload and a conflict between health promotion and patient centredness, all issues which will be discussed later in this chapter.

Four staff connected health promotion with government targets for health promotion in Primary Medical Care. The specialist in health promotion felt GPs tended to fall back on

this model:

> *if you press the button called 'health promotion', even on* (name of GP teacher), *they will revert to seeing it as what the dear old government is telling GPs to do to patients and if you say 'Yes, but that's not all of it', they'll say 'No, no, no, I realise that', and then talk about another agenda.*

Concepts of health promotion: a summary

There were a wide range of concepts of health promotion put forward in interview, but the majority of them were expressed by a narrow range of people. Most people had very little to say about health promotion, apart from implying that it was the same as health education, and was concerned with giving preventive lifestyle advice. It should be recalled however that in this section we are only considering explicit references to 'health promotion' under that exact name: as we shall see, staff had a great deal more to say about some of the topics that are closely related to health promotion, including prevention. So we cannot deduce from this account that staff had little interest in these issues, but simply that they did not tend to connect them with 'health promotion', using that exact term.

We turn now to look at the teaching of health promotion, again under that name specifically, in the curriculum.

TEACHING ABOUT 'HEALTH PROMOTION'

Health promotion in the course as a whole

Table F8 attempts to summarise the state of teaching about health promotion in the curriculum. As will be apparent from the brevity of the table, *'health promotion'* under that name and under the name *'health education'*, was apparently not widely taught. Whether health promotion was taught in the medical curriculum was an issue on which only 12 staff, all 6 interviewed from Public Heath Medicine, and 6 others made comments, despite all being asked about it.

We saw earlier when we looked at health that one member of staff felt that the medical school now put a lot of emphasis on what he called *'promoting healthy lifestyles'*. However, the 4 other staff who commented on this issue were much less optimistic. The overall coordinator of the medical curriculum, referring to what he called, interchangeably, '*health promotion*' and '*prevention'* thought that, *'there is more awareness of it'*, but added that, '*because of the nature of what a medical curriculum is it is still a small part of the total curriculum time'*. The other three staff felt even more strongly that health promotion was not much taught. The coordinator of term five, the Endocrinology, Human Reproduction and Nephrology Systems course, indicated that he did not feel the amount of time given to it

Table F8 ***'Health promotion'*** **and** ***'health education'***[1] **(under those specific names) in the medical curriculum**[2]

Course	In medical curriculum book[3]	According to staff in interview (negative instances in brackets)
Course as a whole		Medical education coordinator said *'very small part'* (3 others said not much taught)
Basic sciences Years 1 and 2		Coordinator said *'may permeate'* Taught through PHM and Psycho-social science (see below)
Term 2	*'The psycho-social component...is concerned with the strategies in practising...health promotion'* PHM lecture: *'Principles of health promotion'*	Health promotion lecture in this term, included: - difference between hp and he - theory of hp - role of doctor in hp e.g. as role models, activists for health & creating healthy environments - limits of role of doctor compared with others - community interventions e.g. Oxcheck
Term 3		*'Small part'*: taught in relation to nutrition and exercise
Term 5		*'Opportunist coverage'*
SBOM (yr 3)		Year 3 coordinator thought taught *'a little on alcohol and smoking'*
Public Health	1 lecture, see above under term 2	2 staff very keen and knowledgeable about hp. Other 4 more ambivalent Lectures cut this year from 3 to 1
Psychology		Said much overlap of content areas, e.g. healthy lifestyles, behaviour change, smoking, models debate
Sociology		Said much overlap of content areas, e.g. inequalities in health, smoking behaviour, models debate
Clinical attach Years 3 and 4		*'Minimally'*
Primary Care		Coordinator said 1 seminar (called *'lifestyle advice'* in materials) taught and some opportunistic coverage in GP placements and OSCE
Total (from 38 potential entries)[4]	**2**	**11**

Notes

1. For this analysis, all the instances counted represent the actual use of the words *'health promotion'* and/or *'health education'*.
2. This table only notes positive instances. If a column is blank, or a course is not listed, it can be assumed that the entry would have been negative.
3. As Public Health Medicine, Psychology and Sociology did not have an entry in the medical curriculum book, their course handbooks have been used instead.
4. *'38 potential entries'* refers to all the categories used for this particular analysis, which were the 31 courses, the course as a whole, 1st and 2nd years, the 3rd and 4th year, the 5th year, and Public Health Medicine, Psychology and Sociology.

in the first two years had increased, and that it was not a priority, *'I haven't really thought about it, but I am not aware, certainly in my own term, of any positive attempt to enhance that area; no, no.'* The coordinator of the third year felt the students would get something on *'prevention'* under specific disease topics, but nothing on the promotion of positive health, *'not health promotion in the sense of, as a way of life, as including it in your general philosophy of practice of medicine, no'*.

Health promotion in Public Health Medicine

Term 2, the Cardio-Pulmonary Systems Course gave rise to the only reference to *'health promotion'*, using that name in the medical curriculum booklet, under course *'content'*, referring to *'the strategies which may be adopted in practising disease prevention and health promotion.'* This entry appeared to refer to the one specific, named lecture on health promotion, given by the specialist in health promotion, which seemed to represent Public Health Medicine's only named teaching on the subject.

In her interview, the specialist talked at length about what she taught students in this named lecture: much of what she taught has been mentioned already when looking at her concepts of health promotion. To recap briefly, she said that she taught students that health promotion is not the same as health education, that it has a theoretical base, that health is influenced by psychological and social factors, that doctors have a role to play in health promotion, especially as role models for health, as advocates and lobbyists, and as creators of healthy environments, but that this role is limited in comparison with that of other agencies. She taught them a little about community interventions, citing in particular medically relevant ones such as 'Oxcheck'.

There were no other uses of the specific words *'health promotion'* or *'health education'* in the teaching referred to by staff from Public Health Medicine. As we shall see, other staff from this group, were involved in teaching about issues that, in the view of this thesis, form part of health promotion, such as 'healthy public policies', and 'risk', but they did not appear to see them as included within health promotion or give them that title when talking to students.

Health promotion in the rest of the basic science courses

The coordinator of the first and second years felt that it was generally difficult to teach health promotion, or *'health education'* as he called it, to medical students directly, but that the messages could gradually permeate through:

> *I don't think one can teach health education to that extent; I think one can make the students aware and by a number of different mechanisms at different times, that they ought to be considering, 'well what can be done to improve the health and the health of a nation', and things like that, and I know for example*

(Public Health Medicine) *do talk about the 'Health of a Nation' document, so again hopefully that is reinforcing that same message.*

However, three coordinators nominated small scale examples of teaching about '*health promotion*' under that name in their basic science courses. The coordinator of the Locomotor Systems course in term three said that the students were taught about health promotion in relation to *'nutrition'* and *'exercise'*, emphasising that he meant health promotion in the positive sense:

(Name) *does quite a few lectures (on) promoting exercise, I think he does a lecture on fitness and exercise and he certainly gets across these general messages. The diet aspect comes into it, but not specifically tied in to disease, more in to promoting health.*

The coordinator of the Endocrinology, Human Reproduction and Nephrology Systems course in term five claimed that health promotion received some opportunist coverage in the course, '*it just happens to be appropriate that certain things come in where they do'*. As already mentioned, he said the course looked particularly at risk factors in diabetes, '*what the sort of danger signs are, you keep your weight down and keep fairly fit and so on'*.

The coordinator of the third year thought that health promotion might be taught, albeit '*only very minimally'*, particularly in the Scientific Basis of Medicine course, where, *'they have a little bit about alcohol, then they have a little bit about smoking, some pretty basic stuff'*, (an assertion which the coordinator of the Scientific Basis of Medicine course confirmed in interview). However she qualified even this limited optimism by remarking that the course did not cover health in the positive sense.

Health promotion in the clinical attachments

In the clinical attachments, the only member of staff interviewed who claimed that *'health promotion'* was being taught under that name was the coordinator of the third year teaching in Primary Medical Care, who was also one of the seminar leaders. He described a seminar he taught on it in some detail. He felt that students would also see examples of health promotion opportunistically in their general practice placement, and, if they recognised it as such, in the 'OSCE' (objectives structured clinical exercise/examination: a half day session, in which a group of students moved through short 'stations' and held consultations with simulated patients with various conditions, on which they were assessed and given feedback by an observer on their performance.)

Although the teaching coordinator used the words *'health promotion'* freely, sometimes interchanging them with *'health education'*, they were not in common use in Primary Medical Care. The teaching manual, the aims of the year and the seminars to which the coordinator referred all used instead the terms *'prevention'* and '*lifestyle advice'*, which

seemed to be preferred by the Primary Medical Care staff interviewed. So the Primary Medical Care seminars, the teaching materials, and the staff interviews, will be looked at in more detail in sections later in the chapter in the section on prevention.

The coordinator of Palliative Care said that to his regret his specialty did not cover *'health education'*, because *'the Trust'* thought it *'unseemly'*, although in his opinion they were well placed to do so with the relatives of dying patients:

> *when I have suggested to the Trust and others that we here are marvellously placed for health education....because we are dealing with lung cancers all the time. ..we have actually people coming who are smoking to see a patient who's dying of lung cancer. What a glorious opportunity for health education, and people think it's unseemly...I mean I just despair..*

The status of health promotion

As with the issue of health, several respondents, unprompted, located their comments on the teaching of health promotion within the wider context of its treatment in medicine as a whole.

One basic science coordinator felt that clinicians do not do much about health promotion, simply because they do not have the time. However all the other 8 who commented on this issue believed that the problem was not that straightforward, and most of them suggested that the area was neglected because it had status problems.

The question of the status of health promotion was clearly a live issue, even within its 'home' in the Medical School in the Public Health Medicine group. The specialist in health promotion was naturally convinced herself of the importance of health promotion, even if her view of the role of the doctor was, as we have seen, rather ambivalent. However she had concerns about the way her subject was treated by the others in her group, saying at one point that she felt that health promotion had the status of *'a Cinderella subject within a Cinderella subject'*. Later she said that she felt health promotion was now being taken more seriously by her group, partly because she had made efforts to use a form of health promotion that was acceptable in that context, in other words an empirical, research based approach:

> *I have had to as always justify that* (health promotion) *but I do believe it is taken seriously now...and I think I have done my best... to set it in a context, like looking at research designs, and looking at published studies, that they* (i.e. those in Public Health Medicine) *would recognise and feel comfortable with.*

However her earlier concerns about how some others in the group saw health promotion appear to have been justified. The Chair of the group was thoroughly positive about it, but

two others expressed more negative views. As we have seen, one lecturer in the Public Health Medicine group saw health promotion as nothing more than rearranged borrowed clothes, and thus felt that health promotion suffered within that group by being 'commonsense'. Another teacher, although seeming more positive himself about health promotion, reported that within their group it was not held even in the esteem accorded to what he saw as traditionally low status areas as '*public health*' and '*nutrition*', saying:

> *it* (i.e. health promotion) *comes down pretty low on the list: it's always considered to be a bit girly and woolly and soft and you know.*

Four staff made comments on the status of health promotion within General Practice as a profession. One of the lecturers in Public Health Medicine felt that health promotion had died a death in general practice now, '*all that health promotion stuff in general practice has collapsed hasn't it essentially, ... that's all just gone to the wall*'. In contrast, a colleague from Public Health Medicine, who had himself been a GP, felt that the evidence for the effectiveness of 'health education' in the context of General Practice was overwhelming, and that it thus represented a vital role for doctors to play:

> *There is no greater an area where a professional can apply and can gain greater health gain than a doctor opportunistically advising on smoking... I mean as there are so many consultations, a million per day isn't it with GPs?*

We have seen that Primary Medical Care staff themselves tended to use the terms *'health promotion*' and '*health education*' synonymously with *'prevention*' and *'lifestyle advice'*, issues that will be discussed later. However, two members of staff did make some specific comments about doctors' current attitudes to *'health promotion*', under that name. One of them expressed mainly positive attitudes. He felt that the public were very aware of health promotion since the 'Health of the Nation' document: indeed he felt the media and what he called *'people out there*' were probably ahead of what was going on in the Medical School in terms of practising health promotion. However he felt that the specific targets set for health promotion in Primary Medical Care were not helpful in practice:

> *a lot of the changes are information gathering, and it is not actually helpful, because you know that x number of people smoke, well I am sure that is valuable in some way but it is actually what you do with them that matters.*

Another member of staff from Primary Medical Care mentioned only negative attitudes. He felt doctors were unenthusiastic about health promotion, partly because doctors were overburdened, under resourced and '*stressed out*', as he put it:

> *there's a question of the importance of health promotion being increasingly recognised, but it is coming on the back of a lot of fatigue in the general medical profession at the moment.*

Like his colleague, he also felt negative about the targets the government had set for GPs, '*as you know we have got all sorts of targets for health promotion and it is all a bit farcical really*'. He felt too that doctors were not convinced that the evidence for the effectiveness of health promotion was yet there:

> *people obviously want to look at the evidence, and the evidence for some of these things is going to take 20 years to emerge.*

Two other staff also criticised health promotion for failing to provide evidence of its own effectiveness. The coordinator of the Genito Urinary attachment remarked that doctors, including himself, tended to be cynical about the efficacy of what he termed '*health education*':

> *Cynicism in the extent that no-one really knows to what extent health education makes a difference and we point to all these trends that we can show and we'll say "well this is health education, but it can also be sheer panic, when all your friends have died."..... and I say "what is the evidence that health education works?"*

Similarly, the coordinator of the Early Patient Contact Human Reproduction course felt that this perception of the lack of proven effectiveness of health promotion was a barrier to staff, including himself, bringing in more teaching about it:

> *if someone can convince me that health promotion actually works....I dare say we could bring it in more effectively.*

So there appeared to be no great conviction among staff that health promotion was important, effective, or formed a strong part of the role of the doctor.

Did staff think there was enough teaching about health promotion?

Unsurprisingly perhaps, the specialist lecturer was the most vociferous in feeling that the coverage of health promotion was inadequate:

> *I really do feel that it is being treated as "we'll give them a dollop of health promotion"...I would hope that it does not remain as one lecture next year.*

Interestingly, an interview with the coordinator of the third year Primary Medical Care attachment suggested that her concern about what one lecture could achieve may have been justified. He mentioned what appeared to be the same input, when he reported that the students said that the lecture they had on 'health promotion' in the first year was rather too sophisticated for them:

...when I asked them, "I am sure you have had sort of talks in health promotion", they said "Well we had something in the first year, but it was a bit above our heads" sort of thing, and that was it.'

Despite feeling that there was not enough time for health promotion, it was clear that teaching her subject to medical students was not a major priority for the specialist lecturer. She said, *'basically I am not interested in medical students'*, and that her reaction on being told that the lecture input was reduced had been ambivalent:

so I thought on the one hand, "thank goodness I've only to give one wretched lecture to medical students", and on the other, "what is going on here?"

She felt she had not the funding, time or energy to agitate for more time. A significant influence on this attitude may have the fact that she was herself not funded by the University or the Medical School, as indeed were few of her colleagues in Public Health Medicine who nevertheless taught on the courses. Many from Public Health Medicine pointed out this anomaly. The specialist lecturer said she was not necessarily wanting more time to teach health promotion herself, but thought there should be more effort put into making sure the health promotion input was properly coordinated. She regretted that she was not very involved with planning teaching, and just given her allocation to teach:

I have never been involved in sitting round a table planning this course, I have always received my dollop, as it were, and been allowed to do what I liked with it.

Perhaps as a result of this lack of involvement, she said she was unsure about why the time allocated to her lectures had been reduced: she thought it possible that it was because others in the department were teaching closely related issues, but without better coordination she said she had no way of knowing. She felt that in any case, teaching *'health promotion'* under that particular heading was not that vital:

it's an attitudinal thing I suppose I am looking for, because if you can change their attitudes they don't have to do anything more.

We have seen that the Chair of the Public Health Medicine group was keen that there be better teaching about health promotion. He endorsed the specialist's view that one way forward was to improve the coordination of the teaching about it:

I don't think anybody so far has seen health promotion as an important part of what students need to know, has had the overall responsibility for checking that there's that thread going through.... I think actually we need somebody with a health promotion background to be seeing that is pushed through, and we haven't had that, and that's bad.

Apart then from the specialist lecturer in health promotion, and the Chair of Public Health Medicine, who both wanted more coordination, there was one other member of staff, the coordinator of the first two years, who expressed regret that health promotion was not more extensively taught to the undergraduate medical students. We have already mentioned his views under the analysis of the treatment of the concept of health in the curriculum, where he expressed the view that medicine and thus medical education was *'still about illness and disease and curing'*, rather than promoting positive health, despite the fact that the students' *'role is going to be as much, or should be as much, in promoting health'*.

Outside of these few remarks, there were no regrets expressed that health promotion was not taught more widely and/or more effectively.

More optimistically, the teaching coordinator from Public Health Medicine felt that this relative neglect of the topic may not have mattered, as by the fifth year the students seemed to have learnt a good deal about health promotion, despite rather than because of what they had been taught:

> *Reassuringly, by the time we get to the fifth year, I vivaed them, I asked some of them, you know, "Diet and poverty tell me about it, and how it might affect health". "Lack of access to decent supermarkets and money to buy fresh fruit and vegetables; how can we get around that? Subsidy? Nature of benefit?". Some of the students could talk for a long time and go off at tangents, and either they have done some wide reading, because I don't think we taught them that much, but something is getting through.*

Summary of health promotion

'*Health promotion*' and *'health education'*, using those exact words, were not themselves cited formally as written or oral aims in the medical curriculum, but the terms were used quite frequently in interviews, by just under half the staff.

Most staff who used and/or commented on health promotion employed the terms loosely, and interchangeably with a range of others, most notably *'prevention'* and *'giving lifestyle advice'*, and most of those who commented on the matter saw health promotion and health education as the same. Other concepts of health promotion were only expressed by a very few staff, and most of them by two staff in particular. Three staff saw health promotion and health education as different, with two of them nominating the social nature of health promotion as opposed to the individual nature of health education as the key difference. Social issues, such as tackling inequalities in health, avoiding victim blaming, creating healthy environments, recognising political influences and engaging in community interventions were mentioned in relation to health promotion by 6 staff. A few staff connected health promotion with psychological issues, most notably with behaviour change,

mentioned by 4 staff. Five staff connected health promotion specifically with Primary Medical Care. Two staff mentioned doctors as role models for health, two mentioned the role of the doctor in creating healthy environments, and one mentioned patient centredness and empowerment in relation to health promotion.

There appeared to be no great conviction among staff that health promotion was important, effective, or formed a strong part of the role of the doctor. Some staff, particularly in Primary Medical Care, had negative views of health promotion, which seemed to be the result of having had bad experiences of having had a specific, top down, interventionist health promotion role thrust upon them by Government without the evidence being there, in their opinion, for its effectiveness, and without regard for the other work pressures they were under.

Common, compulsory, named teaching on health promotion appeared to be mainly confined to one lecture in Public Health Medicine, given by a lecturer who had a 'state of the art' understanding of the subject, but ambivalent attitudes about teaching medical students. There was also some work on nutrition and health in the locomotor systems course which the coordinator regarded as connected with promoting health. There was a seminar on giving lifestyle advice for some students in the third year Primary Medical Care seminars, called by at least one teacher '*health promotion*', and some opportunistic examples in the systems courses, General Practice placements and the OSCE assessment.

Two staff expressed a wish that specific named teaching in health promotion and/or health education be better coordinated across the curriculum, while two wanted more teaching emphasis to be placed on it, and on positive health in general.

PREVENTION

- ***This thesis will examine the extent and nature of teaching about prevention in the medical curriculum, and at the staff attitudes towards prevention.***

Use of the term *'prevention'*

'Prevention' was mentioned relatively often in the interviews, although it was not much mentioned as a specific aim.

A search of the interviews for the words *'prevention'*, *'preventive'* and *'anticipatory care'* is summarised in table F9. It suggests that these words had a wider currency among doctors than those connected with *'health promotion/ health education'*: they were used by over half of the staff interviewed, and those people that used them did so on average 3.8 times.

Table F9: Use of words *'prevention/ preventive/ anticipatory care'*

Group		*prevention/ preventive/ anticipatory care*
3 Overall course coordinators	Number of times words used	11
	Average usage per person using them	1
	Proportion of interviewees using words	1/3 (33%)
7 Basic scientists	Number of times words used	16
	Average usage per person using them	4
	Proportion of interviewees using words	4/7 (57%)
18 Clinicians	Number of times words used	42
	Average usage per person using them	3.8
	Proportion of interviewees using words	11/18 (61%)
5 Primary Care Specialists	Number of times words used	6
	Average usage per person using them	3
	Proportion of interviewees using words	2/5 (40%)
3 Psychologists	Number of times words used	1
	Average usage per person using them	1
	Proportion of interviewees using words	1/3 (33%)
1 Sociologist	Number of times words used	0
	Average usage per person using them	0
	Proportion of interviewees using words	0/1
6 Public Health Specialists	Number of times words used	21
	Average usage per person using them	3.5
	Proportion of interviewees using words	6/6 (100%)
Totals	**Total number of times words used**	**97**
	Total average usage per person using them	**3.8**
	Total proportion of interviewees using the words	**25/43 (58%)**

Note

- Instances of the use of the words that were immediate and simple repetition of the interviewer's question were not counted.

They were used in roughly the same proportions by both basic scientists (4 out of 7) and clinicians (13 out of 23), and by all of the 6 Public Health specialists. However, they were less frequently used by the psycho-social scientists, only one of whom them used them, and that was once only.

As with health promotion, concepts of prevention included 'giving lifestyle advice', meaning talking to people about how they can live their daily lives in a more healthy way, for example by not smoking, by eating wisely, and taking exercise, in order to avoid disease, especially cancer and cardio-respiratory disease. The concept was a wider one though, and included immunisation, screening and other such interventions. 11 of the 43 staff interviewed indicated that they were familiar with the notion of different 'levels' of prevention, making the distinction between '*primary, secondary and tertiary prevention*', using those exact terms. They were the coordinators of the first two years, the Medicine attachment, the third and fifth year Psychiatry attachment, the Genito Urinary attachment, and all 6 staff interviewed from Public Health Medicine.

TEACHING ABOUT PREVENTION

Prevention in the course as a whole

Table F1 which broke down course aims by type has already shown that *'prevention'*, under that specific title, made an appearance as a written and oral aim for the course as a whole. Table F1 and appendix 3 from which table F1 is built up, show that it was cited as an aim 10 times across 6 out of the 35 elements, for two of the basic science courses, and for three of the clinical attachments. So there was some clear intention to teach about prevention across a range of courses in both parts of the curriculum.

Table F10 summarises the apparent state of teaching about prevention in the medical curriculum. As the notes for table F10 say, this section includes 'lifestyle', unlike table F1 which summarised course aims, where 'lifestyle' was counted separately, so the two tables cannot be directly compared. 'Prevention' as it is used in table F10 also includes the topics of 'nutrition', 'cancer' and 'drug interventions', where the context made it clear that teaching about prevention was the intention. So unlike the previous section on health promotion, this section will not restrict itself solely to analysis of where 'prevention' was mentioned under that precise name, but will attempt an overview of areas which many staff clearly saw as component parts of prevention.

Table F10 shows that prevention made an appearance in relation to the course as a whole and both the basic science clinical elements, although it was cited as a written aim mainly for the basic science courses, for 4 out of the 7 courses, and for Psychology, Sociology and

Table F10 *'Prevention'*[1] in the medical curriculum[2]

	In medical curriculum book[3]	According to staff in interview
Course as a whole	Aim *'to provide knowledge and understanding of the principles of prevention'*	Overall coordinator thought it *'touched on'* throughout the course Coordinator of 1st 2 years thought *'more awareness'* of it now, but not much taught overall
Basic sciences/ Years 1 & 2		Overall coordinator and coordinator of 1st 2 years thought it taught through work of Public Health Medicine
Term 1/ Found.		In relation to *'nutrition'*
Term 2 Cardio-Respiratory	Aim: *'understand the factors which motivate people into adopting healthy behaviour patterns'* content: *'practising disease prevention...'* PHM lecture and practical on *'Principles of prevention'* Lecture on *'Foetal origins of disease'* Psychology lectures on: *'Cardio-vascular health'* *'Health belief model'* Practical on *'Smoking health education materials'* Sociology lectures on: *'Health inequalities'* *'Inequalities, poverty and health'* *'Ethnicity and health'* *'Gender and health'* *'Lifestyle, community and health*	Teachers of Public Health Medicine, Psychology and Sociology all said they taught about prevention in this term
Term 3 Locomotor		In relation to *'nutrition'*
Term 4 Neuro	PHM lecture on *'Prevention of head injury'*	
Term 5 Endocrin.	PHM lecture on *'Nutrition, growth and later health'*	*'Not planned or deliberate'*, but said they touched on *'nutrition'* and *'diabetes'*
Term 6 Gastrointestinal and Lympho.	Aim *'prevention in these* (i.e. gastro and lympho) *areas'* PHM lecture *'Screening and prevention of cancer'*.	Mentioned *'sexuality'* and *'alcohol'*
EPC PMC		Incidentally by some GPs
Public Health	5 lectures and a practical: see above under terms 2, 4, 5 and 6. Also taught about epidemiology and risk: see table F12.	All 6 staff said they taught it, especially in term 2 Chair said teaching it a key aim of the group Group added preventive questions in clinical exam Nutrition included in several lectures, although lecturer in nutrition thought this not adequate coverage

Psychology	Sessions on *'the health belief model' 'the prevention of cvd', 'the health behaviour gap'* and *'smoking health education'*	Confirmed focus of lecture programme, especially in term 2, although did not use the word *'prevention'*. Said included work on nutrition in the lecture on the prevention of cvd.
Sociology		Coordinator said included lectures on *'smoking and social class'*
SBOM (yr 3)		Mentioned *'alcohol'* and *'smoking'*
Clinical attach Year 3 and 4		
Child Health	Aim: *'screening and immunisation/ child abuse'*	*'Very much so..more and more emphasis now'*
PMC	Aims: - *'have an understanding of the role of prevention in general practice'* - *'discuss lifestyle changes with patients in an appropriate manner'.*	1 seminar on *'lifestyle advice'*, written in teacher's manual, and taught by some seminar leaders Teaching coordinator said he at least taught about *'health promotion'* and *'giving lifestyle advice'* Teaching coordinator said the simulated patients in the OSCEs presented lifestyle problems
Medicine		*'Secondary'* prevention constantly touched on as part of patient management, mentione*'ischemic disease..* *chest diseas.. liver disease'*
O&G		Initially said no, then thought of many examples: *risks and benefits of HR...antenatal screening... cervical screening*
Psychiatry	Aim*: 'learn about the consequences of stigma for the mentally ill, and understand possible methods of overcoming it*	*'Quite a lot really'*, mentioned: - *'healthy drinking.. prevention of alcohol dependence* - *secondary and tertiary prevention in schizophrenia..'*
Project		If student chooses it
Dermatology		A little teaching on the *'prevention of skin cancer'*
Eyes		*'Very little'*, mentioned *'glaucoma.. squints... screening for diabetic patients'*
GU		*'Essential ... the only point in treating this range of disorders is to prevent the complications'*
Neurology		Opportunistically, mentioned *'strokes'* and *'TIAs'*
Orthopaedics		*'Not a high priority'*, but mentioned *'osteoporosis'* and *'accident prevention'.*
ENT		Opportunistically, mentioned *'allergic rhinitis'*

Year 5		
Child Health		Goals same as 3rd year
Psychiatry		Felt would come up quite extensively, including assessment of risk, mentioned *'self harm..dangerous patients...substance misuse'*
Total (from 38 potential elements [4])	7	**26**

Notes

1. For this analysis, *'prevention'* includes *'risk'*, *'lifestyle advice'* and the topics of *'nutrition'*, *'cancer'* and *'drug interventions'*, where the context made it clear that teaching about *'prevention'* was the intention.
2. This table only notes positive instances. If a column is blank, or a course is not listed, it can be assumed that the entry would have been negative.
3. As Public Health Medicine, Psychology and Sociology did not have an entry in the medical curriculum book, their course handbooks have been used instead.
4. *'38 potential elements'* refers to all the categories used for this particular analysis, which were the 31 courses, the course as a whole, 1st and 2nd years, the 3rd and 4th year, the 5th year, and Public Health Medicine, Psychology and Sociology.

Public Health Medicine. Written references to it were rare in the clinical elements, only three attachments mentioning it in writing: its appearance in the clinical elements was mainly through being mentioned in interview.

Although prevention was mentioned often in interviews, by no means all of the citations in the word search were positive: often staff were commenting on the lack of teaching in this area, and opinions were mixed as to the extent to which prevention was actually taught in the medical curriculum.

The overall coordinator of the medical curriculum, when asked about *'prevention'* answered the question in terms of the work of *'Public Health Medicine'*, indicating that it would be taught mainly through the contribution of that group, and in the first two years. He also felt that it would to some extent be picked up in the rest of the course, although he remarked that it was more difficult to continue such an emphasis in the clinical years.

The coordinator of the first two years tended to agree with this view that work on prevention would tend to diminish as the course went on. He was, as we have seen, overtly and vociferously keen on both positive health and health promotion but felt such ideas were neither supported by the tenor of medicine nor taught much in the medical school: he expressed a similarly pessimistic view of prevention (in fact all these ideas were connected in his utterances: he tended to talk of them interchangeably). Like the overall coordinator he thought that prevention was touched on by the Public Health Medicine group's teaching, but was less optimistic about whether such messages would constitute a strong theme in the rest of the curriculum:

> *I think there is more awareness of it, yes, however I think still because of the nature of what a medical curriculum is it is still a small part of the total curriculum time...*

One member of staff from Public Health Medicine felt that prevention was neglected by the medical curriculum, but ought to be a thread or core skill that runs through it:

> *there should be some more time given to the things that we nail down as a central thread .... preventing things....What's the evidence to stop it in the first place? What's the secondary prevention and tertiary prevention?*

Prevention in Public Health Medicine

So several staff interviewed considered that prevention would naturally tend to be taught predominantly in those parts of the courses taught by Public Health Medicine. As the overall coordinator of the medical curriculum said, when asked about the teaching of *'prevention'*:

if you've got a department of Public Health Medicine... you rather to look to them for the promotion of those ideas and trying to make sure they are well and truly embedded in the curriculum.

'Prevention' was indeed 'owned' readily by all 6 staff interviewed in the Public Health Medicine group. All 6 staff interviewed indicated that they taught *'prevention'*, using that word specifically, which was in contrast to health promotion which, as we have seen, 4 of them thought was taught only by the specialist in health promotion. Table F10 shows that the group taught 5 lectures and a practical with the word *'prevention'* in the title, spread across 4 terms of the basic science terms. The Chair reported that Public Health had attempted to add riders to the clinical questions in the final exam, and those they had tried to add were basically preventive:

we give them about 20 to choose from "And how would you prevent this?" and 'What could be done in the social circumstances to improve the prospects for?

(He remarked later that none of these questions had actually been put in, an issue which is discussed later under 'student assessment'.) When listing what he wanted the students to learn, the Chair of the group connected the basic *'population perspective'* of Public Health Medicine directly with prevention and health promotion:

The third thing is for them to have more of a population perspective and to think about the population impact of what medicine does, which leads of course to the fourth thing, which is to be much more aware of prevention and health promotion than they might otherwise be.

Prevention in the basic sciences

Table F10 shows that prevention was taught in 4 of the systems courses.

Term 2, the Cardio-Pulmonary Systems course was the term in which much of the work on prevention was covered, mainly by the work of the Public Health Medicine and the psycho-social sciences. The name of the overall theme that was used to organise the teaching of the psycho-social and Public Health Medicine component of the term was *'changing health behaviours'*. A written aim of the course was that students *'should understand the factors which motivate people into adopting healthy behaviour patterns'*.

The term two entry in the medical curriculum booklet mentioned prevention under the heading *'content'* as follows:

the psychosocial content of the term is concerned with epidemiological methods, the conduct of trials and assessment of risk and with the strategies which may be adopted in practising disease prevention and health promotion.

As table F10 shows, in this term there were two Psychology lectures on '*Cardio-vascular health*' and '*Health belief model*' plus a practical on *'Smoking health education materials'*, and 5 Sociology lectures on issues to do with '*inequalities'*, *'ethnicity'*, *'gender'*, and *'lifestyle and community'*. The teaching coordinator of Public Health Medicine outlined the various places in which prevention would be covered in Public Health Medicine and Psychology teaching in term 2:

> *Well they get some lectures in a class practical on the different types of prevention, primary, secondary and tertiary.....in the disease specific epidemiology stuff where they get an angle on coronary heart disease they will get something on prevention; there are one or two sessions on particular risk factors, like the Psychologists talk about how they might prevent smoking, so lifestyle, behaviour change....that is probably about it... but there's probably something on screening.*

Another lecturer from Public Health Medicine said there was a *'separate lecture from health promotion on disease prevention'*, while he and another mentioned a '*screening practical'* in the second term Cardio-Pulmonary systems course. As we have seen, the specialist in health promotion also felt she included prevention in her lecture in that term on health promotion, looking at *'prevention programmes mainly the US studies, Minnesota, Stamford and all of those'*. She also incorporated some perspectives on 'lifestyle': to recap, she said that she attempted to teach students the importance social influences on peoples' health related behaviour, not 'victim blaming', and the influence of the doctor as a role model for health.

Three staff who taught this course said that in this term they taught students about 'the limited usefulness of telling people what to do' as a way of changing their behaviour. We have already noted such comments from the specialist in health promotion. Similarly a teacher of Psychology who gave a lecture to the students on *'the prevention of cardio-vascular disease'* in term 2, said that he too taught that:

> *you will get nowhere if you believe that telling people how to be healthy will result in their doing things that will make them healthy...*

The Sociology coordinator also taught students that 'just giving advice' was not an adequate response to the issue of why working class women smoke:

> *we talk about Hilary Graham's work. On the face of it if you are a pregnant women then you don't smoke, but we know certain women from certain socioeconomic groups do smoke. Why? Are they being a bad stupid lot, not complying with advice?*

One teacher of Psychology said that he was keen to promote a positive message, and help students lose what he called their *'passive acceptance'* that coronary heart disease is an

inevitable part of getting older:

> *the prospects for behaviour change are reasonably hopeful.... I point to things like the numbers of people who go jogging... the absolute success of no passive smoking, virtually throughout the country, considerable success in some groups for discontinuing active smoking, a bit on high fibre, and other forms of exercise like swimming and brisk walking...*

He felt these themes were taught quite widely, to the risk of 'overkill, '*I think they're repeated ad nauseam actually, and they* (i.e. the students) *turn off actually.*'

There were Public Health Medicine lectures in term four, the Nervous and Neuroendrocrine systems course on *'Prevention of head injury'*, and in term five, the Endocrinology, Human Reproduction and Nephrology systems course on '*Nutrition, growth and later health'* The coordinator of term five said the term's work touched on *'nutrition'* and '*diabetes*'. In term six, the Gastrointestinal and Lymphoreticular systems course, there was a Public Health Medicine lecture on '*Sreening and the prevention of cancer'*, while the coordinator mentioned work on '*sexuality*' and '*alcohol*' in connection with prevention.

We have seen that the coordinator of the third year thought that the Scientific Basis of Medicine course might include some work on *'alcohol'* and '*smoking*', and that this was confirmed by the coordinator of the course.

So prevention, and in particular the giving of lifestyle advice, appeared to be a theme that was covered quite extensively in the first two years, and ran through half of the basic science courses.

Teaching about nutrition in the basic sciences

As is apparent from table F10, nutrition was a specific area that appeared several times in the basic sciences, being taught in three of the 6 term courses and in the Psychology and Public Health thread. It was commented on by several staff, who usually explicitly linked it with prevention.

The overall coordinator of the first two years, talking of the first two years as a whole, emphasised the importance of nutrition, saying, *'there is one important area that I think prevention is important and I think we are going to be in the process of strengthening ...is nutrition'*. Unlike any of the other issues discussed in this research, except communication, nutrition had achieved the status of being a named *'vertical thread'* that ran through the curriculum, and was the subject of specific and overt coordination, and tracking through documentation. Its high profile in the curriculum may have been because, as the overall coordinator of the medical curriculum pointed out, *'we do have an Institute of Human Nutrition, and we have some keen people ...who contribute to the course for the first two*

years.'

The course coordinator for term five, the Endocrinology, Human Reproduction and Nephrology Systems course emphasised the importance of such work for the term as a whole:

> *the most important aspects are the nutritionists this term because they do an awful lot on... the importance of the nutrition of the mother in relation to the offspring's future life...*

He reported that as part of the Human Reproduction element of the course he taught students about the importance of preventive food supplementation (which he called '*drug interventions*') to prevent specific problems, emphasising that he only taught students about interventions with strong RCTs behind them:

> *I do give them the story of the folic acid trial...reducing a rarish but nonetheless catastrophic abnormality called spina bifida, and that is essential. So that is a variety of a prevention.... it is quite interesting that is based on a rather well carried out, randomised control trial, and one of the scientific messages you can get across to them in that term, are the concepts surrounded by the control trials.*

However one of the lecturers in Public Health Medicine who was a specialist in nutrition, and had some interesting observations on what he saw as the lack of adequate coverage of the subject in the medical curriculum. He felt that, in general, basic nutrition was an area that was neglected, both by medicine in general, and by the medical curriculum in particular. He thought it was neglected even within his own Public Health Medicine group, which he saw as obsessed with *'measuring things'* to the detriment of more obviously useful dietary interventions:

> *I find it very odd because, you know, everybody eats and if you don't eat you die, there is no question that diet is fundamentally important and yet I suppose because it is so important people just dismiss it and very quickly get into saying, "Yeah but we've got to measure this, and this and this...."*

He felt this lack of interest in the everyday, applied aspects of nutrition rubbed off on the students, who became blind to the importance of simple issues to do with diet and weight in their routine clinical practice with patients:

> *In the third year, if someone comes in with angina then they have got to do a critical review of the epidemiology of angina and then link it to their patient, ...very few of them actually think to ask about what the patient eats...fairly fundamental stuff like that ..they'll brilliantly list everything they know of the jargon about all the signs they should have and some of them will occasionally say, "Well he looked a bit fat or his weight was" ... but none of them ask about*

their diet. They'll happily talk about that being a major risk factor for heart disease but not actually ask the chap whether he had a high fat diet or not...

It was even the case that not all examples of teaching on 'nutrition' were positive as far as prevention was concerned. A lecture was given by an outside speaker, an expert on the effect of nutrition on the foetus. According to the Chair of Public Health Medicine, this lecture had *'rubbished'* epidemiology in general and lifestyle approaches in particular, in the context of talking about pre-natal nutrition. The Chair said that some students had reported to him, with some glee, that they had been told that, *'a lot of the time lifestyle stuff is a waste of time because unless you do it when you are a foetus you're wasting your time'*: this was an approach the Chair found *'indefensible'*.

So nutrition had achieved some status and coverage in the medical curriculum, usually but not always in connection with prevention, but not to the extent or in the commonsense way that the specialist lecturer in the subject thought appropriate.

Other preventive topics

The only other reference to particular topics in relation to prevention in the basic sciences was by the coordinator of the term six Gastrointestinal and Lymphoreticular course, who mentioned a symposium on *'cancer prevention'* in which *'we link screening to pathology of cancer, the occupational health aspects of cancer..and try to inter-relate these things'.*

Prevention in Primary Medical Care

Prevention was said to be looked at incidentally by some GPs in Early Patient Contact, Primary Medical Care, which the students experienced throughout terms one to three. According to the course coordinator, the GPs with whom the students were attached in term two tried to make the visits they arranged link in with the *'behaviour change'* theme of the term. She said that:

you will get several of them (i.e. the GPs) *who will ....report that they actually took the students to somebody who still smokes even though they have had a heart attack...a lot of them try to make that link.*

Prevention appeared, on paper at least, to be very central to the third year Primary Medical Care attachment. 1 of the 10 competences that this speciality had fixed as its goals was '*discuss lifestyle changes in an appropriate manner*'. In the staff teaching manual, which contained an outline of the 7 seminars that could be taught, one was called '*giving lifestyle advice*': this seminar included an extended role play about a series of consultations over time with a patient with hypertension, and some student presentations on the best way to talk to patients about 'lifestyle.' The coordinator of the third year attachment himself taught this session, and described it thus:

...that seminar is actually looking at health education in the consultation, so they are looking at how a GP would, with patient X, get them to stop smoking or reduce their alcohol....

He said that the students had to prepare seminar presentations on how they would give 'lifestyle advice' and mentioned that some made use of what appeared to be a particular 'stages of change' theory:

...some of them had in fact looked up models of health promotion, health education, and there is a cycle you have to go through two or three times to get change to happen...

He asked his group of students to do further work in the community, on which they reported back:

... that's one of the different things that I have introduced is that the students actually do a bit of work outside the seminar on health promotion, and maybe go some are very keen and go and visit places like St Dismas which is the alcohol centre, or the dieticians...

He felt that opportunities for giving lifestyle advice also arose in the OSCE assessment. When asked whether some of the simulated patients' problems raised *'health promotion and health education issues'* he said he felt they did:

...yes, they do they... one of them smokes, one of them has a drink problem, there are all sorts of various ones that they can do, yes.

He also felt that students might see opportunistic health promotion in the surgeries in which they were placed:

they might see the practice nurse doing some sort of things or the GP doing something... it depends on the practice they are at and what is happening that day.

This coordinator was clearly a great enthusiast on this issue, and was keen to emphasise how much 'health promotion' and/or *'health education'*, as he called it, was taught by all staff. However the attitudes of other staff in Primary Medical Care to prevention, and the extent to which they reported that they taught it, suggested a less positive picture. All 4 of the other staff interviewed from this group made it clear that, compared with the other competences, those connected with health promotion, health education, prevention and giving lifestyle advice were a low priority, an afterthought. The group had been through a workshop exercise to determine the competences they regarded as 'core' for their teaching, in consultation with the GP teachers with whom they worked. One teacher said that, although this exercise had resulted in the identification of one competence about giving

lifestyle advice, it was not seen as of as great importance as the others:

> *It wasn't given a very high priority, as I remember on the list of competences when we actually discussed this with doctors for various reasons. All the other clinical things were put higher than that.*

It also appeared to be the case that the seminar written in the teaching manual called '*giving lifestyle advice*' was by no means taught by all seminar leaders. One teacher asserted that '*students would not routinely be taught*' anything about such issues in the seminars.

It may be that this relative lack of interest in prevention shown by the majority of staff in Primary Medical Care was because some staff shared the concern, articulated by one member of staff in particular that activities such as 'prevention', and 'taking a population approach' were in opposition to the core values that Primary Medical Care was attempting to transmit. This teacher perceived a fundamental incompatibility between what she saw as Primary Medical Care's central value of patient centredness, and prevention and health promotion. She conceptualised prevention as concerned mainly with population based preventive interventions, which she felt lead to what she summarised as a *'conflict between medicine for the individual and medicine for the population'*. She felt GPs were being asked to persuade patients to undertake procedures, such as screening or immunisation, which were *'measures that are being taken for the good of the population rather than for the good of the individual'*. She pointed out that *'immunisation is the classic example because the best situation for the individual is for them not to be immunised and for everybody else to be'*. She felt therefore that some aspects of the preventive role were in contradiction to the fundamental requirement for the doctor to be on the side of their individual patient:

> *the patient believes that the doctor is working for them as an individual and ..the doctor is then asked to do something that is clearly not in that patients interest..that is very rarely made clear. If you do try and make it clear you are then put in a position of almost asking the patient a favour to help you, which is equally unsatisfactory. I think it is no good.... I think it could be done within a general practice structure but not within a personal relationship between doctor and patient..*

However, not all staff in Primary Medical Care felt this way. The Chair of the Primary Medical Care group also recognised the problem of the *'tension between 'population approach and an individual approach'* but saw this *'as being very interesting'* and something on which her group and Public Health Medicine were *'working on jointly in a productive way'*.

The member of staff who had reservations about the population approach also had a raft of reservations about teaching 'lifestyle advice'. For example, she felt that in the one to one

teaching with GPs the students received, giving lifestyle advice was even less likely to happen with a student there than without, *'dealing with the presenting problem takes longer if you have students, and one is less likely to move on to other areas.'* She also felt that it was difficult for students to demonstrate such competences in the OSCE:

> *I think it is difficult for them to demonstrate it because it is what they feel they are uncomfortable about, it is not having the information or not being sure their information is right.*

In contrast to some of these negative views, another teacher felt that, judging by the OSCE, a few students were '*quite good*' at giving lifestyle advice. However, she went on to say that this must have been despite rather than because of the teaching, *'they have got it from somewhere else, so you can't possibly say that it is coming from the seminars.'*

So, there appeared to be mixed opinions, and mixed messages, about prevention coming from Primary Medical Care.

Prevention in the other clinical attachments

Prevention was said by clinical coordinators to be taught in 9 of the 14 clinical attachments in the third and fourth year, and two of the 6 attachments in the fifth year. The extent to which it was taught, and its apparent centrality within courses, varied a great deal.

Prevention was reported as being covered in a fairly substantial way in three of the third year attachments, namely Child Health, Genito-Urinary Medicine and Psychiatry, all of which saw it as central, and all of which indicated that they taught it at the primary, secondary and tertiary levels.

When the coordinator of Child Health was asked if his course covered prevention he affirmed, *'prevention, yes, yes very much so. More and more emphasis now'.* Aspects of prevention which he said were covered were '*immunisation... health hazards for small children'*, and *'surveillance'*. The medical curriculum booklet described the course content as including '*eating disorders/ developmental paediatrics/ screening and immunisation/ child abuse.'*

Similarly, the coordinator of the Genito-Urinary attachment also said that both primary and secondary prevention were central to the discipline, and talked about how preventive interventions were interwoven with many of the core tasks of the G-U specialist:

> *We are here to prevent complications and we emphasise that to the student. The only point in treating this range of diseases is to prevent the complications....you treat the patient before the complications set in, secondary prevention,...you go out and you find partners who again may be*

asymptomatically infected; you find high-risk individuals and educate them. ...and then therapeutic prevention, getting out and vaccinating people and talking about safe sex and all that.

He even went so far as to suggest it was one of their main tasks, *'so they* (the medical students) *see it applied, practically... well that is what we are here for.'*

The third year Psychiatry attachment coordinator was clear that his course also taught quite a bit on prevention, at the *'primary, secondary and tertiary levels'*, using those terms. When asked how much prevention was taught, he said there was *'quite a lot really'*, and went on to name a large range of specific instances:

certainly in the alcohol seminar, the attachment to the drug advisory service, where there is a lot of discussion about healthy patterns of drinking, and problem drinking, and prevention of development of alcohol dependence. Again in the lectures on depression and schizophrenia in particular, there are all kinds of treatments now, both psychological and pharmacological that can prevent new episodes of illness, that would be secondary prevention. And of course, in this schizophrenia seminar, the principal focus is on rehabilitation which being a tertiary prevention, preventing the development of disability.

All of the third and fourth year attachment coordinators cited so far, i.e. those from Child Health, Genito-Urinary, and Psychiatry, appeared to be clear from the outset of the interview that prevention was a high priority in their teaching. Interestingly though, at least three of the other third and fourth year coordinators all had a 'double take' reaction. When asked whether their course taught about *'prevention'* they initially said no, then, without further prompting or interruption went on to nominate several examples of it in their teaching. For example, the coordinator of third year Obstetrics and Gynaecology said initially, *'no, we don't really'* and then went on to cite quite a comprehensive roll call of preventive topics:

It comes up in discussion of things like HRT, benefit risk type discussion, cardio-vascular prevention. Screening of course comes up in antenatal....so you have the public health issues about sensitivity, specificity of the tests we are using.. and the whole issue of informed screening as to whether the patients really appreciate what they are having a scan for or a blood test for, which very often they don't..then we've got things like cervical screening for cervical cancer.

The coordinator of the Medicine attachment had a similar, initially negative, response when asked about the teaching of *'prevention'* in his course, replying with a grin *'could be a brief conversation'*. He then went on to be a great deal more positive, indicating that 'prevention' may not have been covered formally, but came up all the time because so much of the disease the students see was related to lifestyle. He itemised a detailed list of relevant

conditions, which included:

> *the etiology of ischemic disease and chest disease.... liver disease...hepatitis viruses are sexually transmitted, anal, foetal route for some of the other diseases.*

He concluded that *'primary prevention of disease does get raised on a fairly frequent basis'*. When considering the students' clinical contact with patients, he felt that primary prevention would not be much talked about, but that secondary prevention was covered constantly: *'secondary prevention will get touched on, I mean, that's constant, it's part of one's patient's management'*.

Such 'double take' reactions suggests that perhaps there was more teaching on prevention actually taking place than might appear to be the case from staff responses, and it may be that the negative responses from some coordinators masked some more positive instances that longer interviews or a different research approach would have uncovered.

In another 5 of the 14 third and fourth year attachments the coordinators suggested that prevention was covered to some extent, but in these cases it appeared to be very much in passing. Each named some specific preventive topics that were taught. Like the coordinators mentioned earlier, the coordinator of the Eye attachment did a 'double take', initially saying that '*very little*' was taught on prevention, but then thinking of one or two examples of conditions that were preventable and which the students would learn about. He mentioned *'glaucoma ...children with squints ...screening patient's who have diabetes ...I suppose is preventive'*. The coordinator of the Dermatology attachment said the students were taught about the major initiatives that were around to *'prevent skin cancer'*, although he personally was sceptical about them. Orthopaedics was said to cover a little on '*osteoporosis and accident prevention'*, but the coordinator went on to emphasise that prevention was not high priority due to lack of time, *'it doesn't compete really.'* Two coordinators said that such teaching was opportunistic: the coordinator of Neurology said that '*strokes and TIA's'* might be mentioned, while the coordinator of ENT said that '*allergic rhinitis'* might crop up: both said it would all depend on what patients presented themselves at the clinics.

In contrast to these fairly positive examples, the coordinator of the Geriatric medicine attachment stated explicitly that prevention, and in particular giving lifestyle advice, was not relevant to his specialty:

> *If you are 85, you have outlived most of your birth cohort, so whatever you have been doing must be pretty good, so I am not about to start telling you mustn't eat eggs or something like that, so it's 'get real' if you like....*

Throughout the rest of the interview this coordinator was keen to emphasise the 'patient centred' approach of the attachment. The implication was that he shared the feeling of the Primary Medical Care teacher, noted above, that there was an inevitable incompatibility between patient centredness and prevention.

One other coordinator, who was responsible for the third year Surgical attachment positively said that he did not feel that 'prevention' was covered in that attachment; he indicated that he thought it would be better covered in other attachments, as it was just not particularly relevant to surgical conditions, *'just by the nature of the sort of things we see there aren't as many preventative issues as there would be in other areas'.*

Looking at the fifth year attachments, the overall coordinator of the medical curriculum felt that certain messages and preventive practices, particularly those linked with 'lifestyle advice' were becoming commonplace:

> *I would like to think that all clinical attachments have elements of health promotion, and certainly anyone who goes and does an attachment of, say, in General Medicine in the final year, you're aware of the kind of things that are going on to try and encourage people to adopt healthy styles as well as learning to take their medicines.*

He later said that all students going through a fifth year clinical attachment would realise how important secondary prevention was:

> *it's a standard practice for patients, after they've recovered from a myocardial infarction and gone home, to be offered a cardiac rehabilitation course which involves possible changes to their lifestyle.*

In the fifth year, the coordinators of two of the 6 attachments mentioned teaching prevention. The coordinator of the Child Health attachment simply said that their goals in this area were the same as in the third year. The coordinator of the Psychiatry attachment outlined what he felt that students would cover in the way of aspects of secondary and tertiary prevention, and remarked: *'I think an awful lot about community mental health care now is at a preventative level.'* He mentioned *'preventing harm to self and others from dangerous patients, assessment of risk'* and *'substance misuse'* as the topics he would expect students to cover, although he emphasised that *'they are at the mercy to some extent of individual consultants as to how much they pick up about that'.* He also felt that patient education was basic to much Psychiatric therapy, *'when people talk about psychological treatment they are often just talking about education'.* He mentioned some of the areas about which they educate patients, *'about treatments, about side effects, about services... and education for families'.*

Prevention and giving lifestyle advice were not specifically mentioned by any other fifth year coordinators, despite their being questioned about it. It may of course be that, as the overall coordinator of the medical curriculum said, and as the 'double take' reactions of the third year coordinators indicate, that the fifth year coordinators took its existence so much for granted, that they had ceased to notice its presence.

The status of prevention in medicine

Several staff commented on the status and priority of prevention within medicine as a whole.

As we have seen, one member of staff in Primary Medical Care was very concerned about what she perceived as the conflict between the ' population approach' inherent in some preventive interventions, such as 'immunisation', and the 'patient centred' approach she saw as central to Primary Medical Care, while the coordinator of the Geriatric Medicine attachment also felt that 'prevention', and in particular the 'giving of lifestyle advice' was inappropriate for his specialty.

The Dermatology attachment coordinator said he was personally rather cynical about the science behind some preventive strategies, although he felt it was appropriate to give simple messages that the public can understand:

> *If I'm honest I don't think that any of the skin cancer strategies are really based on any great science at the moment and I don't think that they will stand the test of time... the proportion of skin cancers which can probably be directly attributable to some exposure risk I'm sure are greatly over emphasized... (but) to a certain extent it has to be, because as soon as you start making the message much more complicated then Jo public can't take it on board.*

Apart from these comments, few staff reported themselves as feeling especially critical of *'prevention'*, using that precise term. However, as we have seen two were themselves critical of the lack of evidence that what they called *'health promotion'* works, while another, not himself critical, felt others were. As they and others tended to see *'health promotion'* and *'prevention'* as synonymous, we might assume that these negative attitudes, and concerns about effectiveness reported in relation to health promotion might be applied to prevention too.

The coordinator of the Surgical attachments in the third and fifth year thought prevention was *'sensible'* but he felt that it was hard to identify specific preventive approaches that were appropriate to surgical conditions:

> *Most surgical disease, although it has a basis in lifestyle and social circumstances, it's quite difficult to define...although some general health*

advice, you know, high fibre, fresh fruit that we're being told to eat every day.....all these are sensible in respect of surgical diseases, but they're not specific.

In contrast, 6 respondents were themselves positive about prevention, and commented with sadness on what they saw as the negative attitudes held by the medical profession towards it. For example, the fifth year Psychiatry coordinator felt that Psychiatry generally did not do enough to prioritise what he called *'primary prevention'*:

One of the areas where I feel we really fail actually is in terms of the next generations who are patients, because we know that our patients have had all the adverse experiences that you could catalogue in their early lives, and you can see it just repeated with their children, not surprisingly, and it is very hard because there just isn't any resource to call on to say well "could we do anything preventive here?"

One of the lecturers in Public Health Medicine summarised what he saw as the disparaging view of prevention commonly held by doctors, *'worrying about before they even get there in terms of what prevention is, why in the hell would you want to do that?'*. He felt that what he saw as medicine's tendency to spend money in flamboyant but inefficient ways was located within the basic nature of doctors, whom he characterised as mesmerised with *'high tech.'* innovations and *'boys' toys'*. He felt this caused doctors to be much less interested in the *'low tech'* preventive solutions which would be more appropriate for the health problems they faced:

the sort of people who go into medicine come from a certain stratum of society: young boys interested in toys and technology, and epidemiology is very low tech. So you don't zap people with wizzy scanners and ....people are more impressed by equipment and technology and they think if you have a CAT scanner and an NMR or MRI, it will be much better than actually sitting down and talking to somebody about what they eat or what they feel about something...just mention cancer and people throw money at things that are really quite stupid....the pictures are brilliant that you can get from these scans but whether they actually help in a substantial sense across the whole person.... It's probably too late anyway once they get into hospital, ...the notion of keeping people out of hospital ... they don't really do that: there's so little money relative to primary prevention ....

One of the teachers of Psychology also felt that medical teachers do not give sufficient weight to 'prevention':

I've had arguments with doctors who say its not my job to give them advice on preventing disease, and that was from someone in the University health centre!

Summary of prevention

Prevention proved to be a more familiar concept to medical teachers than health promotion and/or health education. Like health promotion, it was seen as including giving lifestyle advice, but also as taking in interventions such as screening and immunisation. Over a third of those interviewed talked about the distinction between primary, secondary and tertiary prevention.

Prevention was listed as a written aim for the course as a whole. In the basic sciences, prevention was listed as an aim for two of the systems courses, and was mentioned as an aim by coordinators of Public Health Medicine and Psychology. The term two Cardio-Pulmonary systems course was said to focus especially on teaching about prevention, and particularly the giving of lifestyle advice, mainly through the work of Public Health Medicine, Sociology and Psychology. Three other systems courses touched on prevention.

Nutrition had achieved the status of being a vertical thread across the curriculum, and was seen as being a focus in the curriculum as a whole. Three of the basic science courses were said to teach about 'nutrition' in the context of prevention, although it was sometimes treated as a biological rather than as a preventive issue. One lecture on the topic was even said to be explicitly hostile to the idea of prevention, giving students the message that the only diet which had any impact on later health was that of the mother on the foetus.

Prevention was taught in 9 of the 14 clinical attachments in the third and fourth year, in just over half the cases this was only in passing, and in two of these, opportunistically. Giving lifestyle advice was taught in 4 of the third and fourth year attachments, namely Primary Medical Care, Child Health, Psychiatry and Medicine, and thought inappropriate by the coordinator of the Geriatric medicine attachment. It was not mentioned by any other third and fourth year coordinators. In the fifth year, prevention was mentioned only by the coordinators of Child Health and Psychiatry, although the overall coordinator of the medical curriculum thought that secondary prevention would be routinely covered in all the fifth year attachments, so it is possible that other coordinators simply took its presence for granted.

Prevention received particular attention in Primary Medical Care. Some of the GPs who took the students on their Early Patient Contact visits were said to link the visits with the preventive theme of term 2. In the third year prevention constituted 1 of the 10 competences taught by the attachment. The group's teaching included one seminar on the topic of giving lifestyle advice, written in the teaching manual, and taught by at least one seminar leader. However the attitudes towards prevention of staff from the Primary Medical Care group and the extent to which they taught it, were in practice very variable. Only one of the Primary Medical Care staff interviewed was especially enthusiastic about it

or did much teaching about it, the others made it clear that it was not as great a priority as their other core competences they had set themselves to teach.

Five staff, in Public Health Medicine, Psychology, Sociology and Primary Medical Care, said that students were taught about 'the limited usefulness of telling people what to do' as a way of changing behaviour. There appeared to be several inputs which attempted to convince students of the need for more sophisticated alternative approaches to lifestyle change. They included a role play in the third year Primary Medical Care attachment on giving lifestyle advice, involving a series of consultations with a person with hypertension; a '*smoking*' practical in Psychology in which students engaged in role plays about helping patients give up smoking; lectures in Sociology on the work of Hilary Graham on the complex social reasons why working class women smoke; and the wider, socially and community oriented approaches to health promotion put forward in the specialist lecture on the subject.

A few staff (4) expressed doubts about the effectiveness of prevention, as they had with health promotion. A few others (6) felt positive about prevention themselves, but did not feel that it had a high enough profile within medicine. One member of the Primary Medical Care group, and the coordinator of the Geriatric Medicine attachment both felt that prevention was incompatible with the patient centred approach they wished to take.

Nevertheless, half of the courses in the medical curriculum were said to teach about prevention, and in particular the giving of lifestyle advice, to some extent.

CHAPTER FOUR

FINDINGS

PART TWO:

PSYCHO-SOCIAL PERSPECTIVES AND ISSUES, HOLISM, PATIENT CENTREDNESS AND COMMUNICATION

INTRODUCTION

The concepts and principles of health promotion across the curriculum

The discussion so far has been restricted to where '*health promotion*' appeared in interviews and documentation, using that specific term, and to discussion of topics overtly connected by staff with prevention. However, as was argued in the rationale chapter, this is by no means the only, or even the most useful, way of looking at the issues embedded in health promotion, and to stop at this point would give a very partial picture. To recap one of the objectives of the thesis:

- ***This thesis will not restrict its vision to where health promotion and/or health education were taught under those exact titles, but will attempt to discover evidence for the concepts and principles of health promotion, wherever they were found and whatever they were called.***

So we turn now to look at the issues which the rationale chapter has argued constitute health promotion, where they occur across the curriculum, and regardless of whether or not medical teachers saw them in that light. We begin by looking at psycho-social issues in the medical curriculum.

- ***This thesis will examine the extent and nature of teaching about psycho-social aspects of health, illness and disease in the medical curriculum, and staff attitudes towards these issues.***

How the psycho-social elements and Public Health Medicine were taught

It may be helpful at this point to say a little more about how the psycho-social sciences of Sociology and Psychology, and Public Health Medicine, were taught. Each of the terms of the first two years had a '*psycho-social and Public Health Medicine theme*', which

attempted to link these subjects with one another and was also intended to relate in some way to the body system that was the subject of the term. So the three disciplines had tailored their inputs to these themes, and each had about 22 hours contact time over the six term, although it was not divided equally between the terms.

How this teaching was organised had varied greatly over the previous few years. Following a period of attempting to integrate their work more closely, and abandon disciplinary labels at least as far as the students was concerned, staff from the three disciplines were now making clearer to students which discipline they came from, and the distinctive contribution of that discipline to the study of medicine. Attempts to teach through group work had also mostly been abandoned, and the three subject areas were now taught almost entirely through lectures, although the odd '*practical*' in which students worked in groups of 20 or so, remained. The reasons for these changes, and their impact on teaching are issues that are of interest to this thesis, and will be looked at in more detail later.

Psychology, Sociology and Public Health Medicine were separately identified, and seen as different by the specialist staff who taught them, and so we will first look at social and psychological approaches separately. We begin with social perspectives and issues.

SOCIAL PERSPECTIVES AND ISSUES

- ***This thesis will look at the extent and nature of teaching about the social issues in the medical curriculum, and staff attitudes towards social issues.***

Social perspectives and issues in the course as a whole

Table F11 summarises the teaching of social issues in the medical curriculum. As the table makes clear, *'social'* aspects, under that name, tended to appear mostly in the basic science elements of the course. They were mentioned orally or in writing in relation to 18 of the 38 course elements. They had a particularly strong presence in the basic sciences, where they were mentioned in relation to: the course as a whole; the basic sciences as a whole; the Foundation course; all 6 of the systems courses; Psychology, Sociology and Public Health; and the Scientific Basis of Medicine course. Mentions in relation to the clinical elements were fewer: *'social'* aspects, using that word specifically were cited orally or in writing for the years 3 and 4 as a whole, and for 5 clinical courses. However, as the table suggests and as we shall see later, social aspects were to be found across a wide range of clinical courses, under the title '*holism*'.

Social perspectives and issues in Sociology

Most of the references to *'social'* issues in the basic science courses appeared to be to the

Table F11 ***'Social perspectives and issues'*** **in the medical curriculum[1]**

	In medical curriculum book[2]	In outline of Sociology course: Lectures on:	According to course coordinator staff in interview (negative instances in brackets)
Course as a whole	Aims *'to provide knowledge and understanding of:* *-human relationships in the context of the family, community and society'*		
BASIC SCIENCES		See below	Medical education coordinator said the basic sciences were taught by, among others, psycho-social scientists, and *'designed to help students get an integrated view'*.
Term 1 Foundation	*'Introduces the psychosocial sciences'* Aim *'to understand the range of factors, physical, psychological and social that can result in illness'*	*'Introduction to sociology'* *'Doctors, patients and professions'* *'Social meanings of illness'* *'Non-orthodox therapies'* *'Stigma'* *'Doctor-patient communication'*	Said essays covered *'wider sociological and health educational'* aspects
Term 2 Cardio-Pulmonary	Objective *'understand the multi-factoral nature of disease'*	*'Health inequalities'* *'Inequalities, poverty and health'* *'Ethnicity and health'* *'Gender and health'* *'Lifestyle, community and health'*	
Term 3 Locomotor	Aim *'to consider the factors that influence ...development and health experience'*	No Sociology lectures	

Term 4 Nervous	'Psycho-social' listed among 9 *'sciences'* taught	*'Changing families and changing demography'* *'Contemporary marriage and the family'* *'Childhood as a social construction'* *'Lone parent families'* *'Family's role in health'* *'Social aspects of old age'*	Talked of integration of psycho-social issues in the case studies
Term 5		*'An introduction to health policy in the UK'* *'Resources allocation, priorities and rationing in the NHS* *'The health and social care interface'* *'Doctors as managers'* *'Primary Care and the NHS'* *'Consumers or patients? involving the patient in the NHS'*	
Term 6 Gastro			Talked of integration of the psycho-social sciences in case studies
Sociology[2]	See separate column	See above	Said aims were to help students: understand what social science has to offer doctors, see how it integrates with medicine and is central to being a good practitioner; look holistically at medical phenomena; acquire a critical perspective on medicine, and understand how they are viewed by the rest of society
Public Health[2]	Lectures on *'epidemiology'* and *'risk'*: see table F12 Lecture in term 1 on '*Variations in health*'		Chair said it aimed to teach students '*to be more accepting of the social sciences way of thinking'* Taught about epidemiology, risk and healthy public policy
Psychology[2]	Some overlap of content with psychological issues: see table F13		One said they also taught a social perspective.

SBOM (year 3)	Aim *'to integrate the basic scientific knowledge acquired in the first two years into a clinical context'*		

CLINICAL COURSES	**In medical curriculum book[2]**	**According to course coordinator staff in interview (negative instances in brackets)**
EPC Human Reproduction	Aim *'to appreciate the importance of the patient's social and economic background in relation to a clinical situation'*	
EPC PMC	Aim *'to illustrate the ways in which psychological, sociological and physical factors may all interact and contribute to illness'*	
Clinical attach Years 3 and 4	Aim *'to reinforce the basic biological and psycho-social sciences which were taught in the first two years'*	Appeared implicitly, through the notions of 'holism' and 'patient centredness' (see tables F15, F16 and F17)
CFC	Aims - *'having a social orientation'* - (students be) *able to assess psychological well being'*	
PMC		Said had appointed an anthropologist who taught on the course Chair saw group as having '*integrative focus'* One teacher especially keen on *'social science view of the world'*
Palliative Care	Aim '*understand the range of psycho-social issues for patients and their families'*	
Project		If student chooses it
O&G	Aim (students) *'become familiar with the social and psychological factors in human reproduction'*	
Total (from 38 elements)[3]	13	10

Notes

1. This table only notes positive instances. If a column is blank, or a course is not listed, it can be assumed that the entry would have been negative.
2. As Public Health Medicine, Psychology and Sociology did not have an entry in the medical curriculum book, their course outlines have been used instead.
3. *'38 elements'* refers to all the categories used for this particular analysis, which were the 31 courses, the course as a whole, first and second years, the third and fourth year, the fifth year, and Public Health Medicine, Psychology and Sociology.

work of the Sociology course which ran through them, and so it will be useful to examine the teaching of that course in a little more detail.

Unlike the tables so far included, table F11 has added an extra column in which to analyse the course outline of the Sociology course, as Sociology, unsurprisingly, covered a great many social issues. As entries in that column make clear, many of the lectures given on the Sociology course were concerned with issues that are of central relevance to health promotion. Those that, to judge by their titles, were particularly relevant, and which overlapped directly with issues raised in the rationale chapter, were: '*inequalities, poverty and health*'; '*lifestyle, community and health*'; '*doctors, patients and professions; 'social meanings of illness*'; '*doctor-patient communication*'; '*family's role in health*'; '*introduction to health policy in the UK*'; '*primary care and the NHS*'; and '*consumers or patients? involving the patient in the NHS*'.

We have already seen, when we looked at '*concepts of health promotion*' that the coordinator of Sociology thought there were obvious overlaps between Sociology and health promotion: he cited in particular his teaching about smoking, and the work of Hilary Graham on the reasons why working class women smoke. He was also interested in the theory of health promotion, and was, for example, aware of the difference between health promotion and health education. When asked specifically about '*the radical social change model*' he said that, although he personally '*have a lot of sympathy with that*' he '*doubted very much if it is going to be taken up...regardless of which government has been elected.*' He therefore saw little point in teaching it to medical students.

The coordinator of Sociology was keen to emphasise that they were not aiming to teach the theory of the discipline for its own sake, but to help students see the practical application of Sociology to their everyday work as doctors. He felt that students did not need to be '*Sociologists or Psychologists themselves*,' but needed to understand that '*some of the things that social science has to offer are absolutely essential to good medical practice*'. He nominated some of the ways in which '*Sociology is central to being a good practitioner*':

> *pragmatic things, like doctor-patient communication, to more subtle things like diagnosis and thinking about issues to do with cultural differences and their understandings of health. I could go on....*

He felt that Sociology had a vital role in supporting '*pronouncements that come from GMC, and the Royal College of General Practitioners*' about the need to '*look more holistically at phenomena*'. But he felt that, although those responsible for national policy might appreciate its importance, the Medical School itself was not comfortable with looking at what he called '*collective*' issues. He felt that Psychology fitted more easily with the

individualistic approach of medicine:

> *because it's more individually orientated and also it therefore has a better fit with that kind of system. Because Doctors spend most of their time focusing on how people behave, and I think Sociology and Anthropology are more focused on groups and collective actions, collective behaviour, which is why I think we do have to struggle to get our message across.*

He felt however that this neglect of the *'collective'* was not helpful to the students' later practice, where social issues would impact greatly:

> *It does seem to me that the medical education at Southampton is still very individualistic, and actually I think we are not doing students any favours doing that, because they are going to come out and go into practice where they are going to have to deal with individual phenomena, with signs and symptoms which are collective differences and difficulties, and look holistically at medical phenomena.*

Although critical of the kind of 'doctor bashing' in which he thought Sociologists had too often engaged in the past, he saw Sociology as having a role in helping students develop a *'critical perspective'* on medicine, and understand how others might perceive them in their professional role:

> *Certainly one of the things they get in the first term* (i.e. in the Sociology course) *in line with their Early Patient Contact, is to consider the role of a profession and the kind of perceptions that people are going to have of them in the following week or two when they go out and meet the patients, and the power dimensions that are engaged in that.*

Apart from this, the coordinator did not discuss the content of the Sociology teaching any further, despite being pressed on it. When asked to elaborate on the course content he deliberately changed the topic to discuss another that was clearly more burning for him, that of how Social Science was seen and treated by the rest of the medical school:

> *I will have to take one step back before I can answer that question, is that OK? ....because it probably needs to have my kind of perceptions of how Social Sciences fit or don't fit in*

The issue of how the psycho-social sciences was viewed and treated by the rest of the Medical School was clearly of such concern, not just to this coordinator, but to many others, that it will be discussed in detail a little later.

It would appear to be the case that many of the most central social issues that were of concern to health promotion were indeed of interest to the Sociologists teaching in the medical curriculum, and many of them were being covered, albeit only with the kind of brevity that a one hour lecture dictates, and within an overall context that did not appear to

support the '*collective*' approach they demanded, and within which the Social Sciences did not easily fit.

Social perspectives and issues in Psychology

One of the teachers of Psychology saw Psychology as teaching a social as well as a psychological perspective, reporting that one of their goals was to help students:

> *realise that people are more than a bag of bones, they have minds, they have emotions, they also have social contexts in which they live.*

She thought the students found taking a social perspective difficult, to judge by the answers some of them gave in examinations, and gave a vivid example:

> (name) *and I designed this study which actually talked about a single woman who had three children and she was pregnant and she was a smoker, and then set a number of issues, all problem solving questions in primary* (the students' first formal examination). *Five students wrote about <u>him</u> in response to the question!*

She too thought that what she termed the *'population'* focus of Sociology and Public Health Medicine was harder to assimilate into the medical approach than was the individual focus of Psychology:

> *Psychology is ...actually looking at individuals, and that fits quite well with the medical group, which is very individually based. While Sociology and social policy and Public Health Medicine and epidemiology are population based studies, and their analysis is very different*

Social perspectives and issues in Public Health Medicine

Although staff from the Public Health Medicine group, especially the lecturer in health promotion, sometimes mentioned teaching a psychological perspective, in so far as they talked of themselves as teaching psycho-social science, most of them tended to see themselves as more closely aligned to a social perspective.

However, they were ambivalent about even this. The Chair of Public Health Medicine was very positive about the importance of what he called *'social science'* in medicine, and saw teaching students '*to be more accepting of the social sciences way of thinking about medicine and not dismissive of it'* as a central goal for his group. But it was not clear whether he saw his own specialty as part of the social sciences, or as a separate discipline, engaged in giving the students the tools to reflect on these and other forms of science.

Statements of other staff in the group were similarly ambiguous on this issue. Sometimes they appeared to conceptualise themselves as teaching what they called *'social science'*. For

example, one lecturer from the group said he saw his teaching as concerned with *'how social events impact on people's health.'* However, from time to time several staff in this group emphasised that they were not teaching social science because they themselves were not specialists. As one said, *'none of us really have the expertise'*, to which another of the group added, bluntly, *'I don't know anything about it: I am not a Sociologist'*. He remarked that they even left it to the Sociologists to teach what he saw as social aspects of Public Health Medicine:

> *the Sociologists teach what I would say was more the Public Health bit on the social determinants of health. It is very much from a Public Health, social statistics type point of view, inequalities, mortality and morbidity, and gender differences.*

More positively, he said the group wanted more links with the Sociologists, *'we need to work side by side with Sociologists, and say what bits of sociological theory are important'.*

Although ambivalent about their role in teaching social science, the Public Health Medicine group had the central role in teaching three issues which the rationale chapter included under a social perspective, namely epidemiology, risk, and healthy public policy. So these issues will be looked at next, under this heading of *'social perspectives and issues'*, even if the staff who taught them may not have conceptualised them as such.

Epidemiology

Table F12 summarises inputs in the medical curriculum on epidemiology and on an issue that staff often associated with it, risk.

Table F12 shows that epidemiology was mainly taught in the basic sciences courses, with 5 of the 7 mentioning it in their aims or content. In contrast, in the clinical years, epidemiology was mentioned only in relation to the two Psychiatry attachments in the third and fifth year.

Epidemiology appeared to be taught only by the Public Health Medicine group. As will be apparent from table F12, the group taught 8 lectures and two practicals on various aspects of epidemiology. The bulk of their teaching on this subject was in term two, the Cardio-Pulmonary systems course, which as we have already seen had as its theme 'changing health behaviours' and was very involved in teaching prevention, thus forming a link between epidemiology and prevention. The group's contribution to this term was in fact usually referred to by staff from Public Health Medicine as *'the epidemiology course'*, described by the group's teaching coordinator as *'probably the most intensive block that we have'*. This coordinator said that the basic epidemiology in this term was followed up in later terms by further lectures that were appropriate to the system in question:

Table F12 *'Epidemiology'* and *'risk'* [1] in the medical curriculum[2]

Course	In medical curriculum book[3]	In outline of Public Health Medicine course: Lectures on:	According to staff in interview
Term 1 Foundation		*'Descriptive epidemiology'* (2 lectures and a practical)	
Term 2 Cardio-pulmonary systems course	Aim *'understand the multi-factoral nature of disease and what is meant by risk and be able to construct a simple epidemiological study'*	*'Descriptive epidemiology'* *'Association, causality and risk'* *'Risk'* (practical) *'Nutrition epidemiology'* (lecture and practical) *'Asthma epidemiology'*	PHM teaching coordinator called their input this term *'the epidemiology course'*. Said it covered *'epidemiology study design, risk, randomised control trials and evidence-based medicine.'*
Term 3 Locomotor	Content *'..epidemiology of some bone diseases'*	*'Epidemiology of osteoporosis'*	PHM teaching coordinator *said 'epidemiology of osteoporosis'* covered
Term 4 Nervous and Neuroendoc-rine Systems	Aim *'to introduce students to the epidemiology and public health aspects of neurological disease'*	*'Epidemiology of stroke'* *'Epidemiology of multiple sclerosis*	PHM teaching coordinator said *'multiple sclerosis epidemiology'* covered
Term 5 Endrocrinology Human Repro & Nephrology			Term coordinator said risk factors for diabetes covered, *'the sort of danger signs: you keep your weight down and keep fairly fit and so on'*
Term 6 Gastrointestinal and Lympho. Systems	Aim *'to facilitate students' understanding of aspects of epidemiology of the gastrointestinal and lymphoreticular systems...'*	*'Quality and quantity of life'* *'Epidemiology of hepatitis'* *Epidemiology of stomach and bowel cancer'*	PHM teaching coordinator said *'cancer epidemiology'* covered

Public Health	see separate column	see above	5 of the 6 saw teaching epidemiology as what PHM was centrally about
Psychology	Lecture on '*Cardio-vascular health*' included risk factors		One said *'identification of risk'* one of their themes One taught about risk factors in cvd
Scientific Basis of Medicine	Content *'the principles of epidemiology'*	'*Principles of epidemiology'* (3 lectures)	PHM teaching coordinator said the group delivered a series of lectures on epidemiology

Clinical attach Year 3 and 4	**In medical curriculum book[3]**	**According to staff in interview**
O&G		*'Benefit-risk discussion'* in relation to HRT
Psychiatry	Aims - *'revise and apply their knowledge of relevant basic science (including ...epidemiology)* -'*learn to assess the risk of suicide and deliberate self harm'*	*'Assessment of risk of suicide and self harm*'
Project		If student chooses it
Dermatology		*'Exposure risks'* for skin cancer
Eyes		'*Children at risk of getting, say, squints*'
Yr 5 Psychiatry	Aim *'have a sound knowledge of common psychiatric disorders...knowledge means...epidemiology'*	Said taught about '*assessment of risk*'
Total (from 38 elements)[4]	9	13

Notes

1. For this analysis, all the instances counted represent the actual use of the words '*epidemiology'* or '*risk'*.

2. This table only notes positive instances. If a column is blank, or a course is not listed, it can be assumed that the entry would have been negative.
3. As Public Health Medicine, Psychology and Sociology did not have an entry in the medical curriculum book, their course handbooks have been used instead.
4. *'38 elements'* refers to all the categories used for this particular analysis, which were the 31 courses, the course as a whole, 1st and 2nd years, the 3rd and 4th year, the 5th year, and Public Health Medicine, Psychology and Sociology.

> *so in term three* (name) *teaches on the epidemiology of osteoporosis, term four is teaching on multiple sclerosis epidemiology, in term five there is nothing, in term six there is some cancer epidemiology.*

As table F12 shows, the group's course outline confirmed this.

The group also taught on the Scientific Basis of Medicine course in the third year, which included *'the principles of epidemiology'* as part of its account of content in the medical curriculum book, among 15 *'sciences'* and *'topics'*: the group's course outline showed that three lectures were taught on this subject.

The teaching of epidemiology appeared to be seen by all in Public Health Medicine as one of their major goals, and in the minds of some, their only goal. Indeed it often appeared in the interview that in the minds of 4 of the staff interviewed *'Public Health Medicine'* and *'epidemiology'* were more or less synonymous, as they used the words completely interchangeably, and usually referred to what they taught and practised as *'epidemiology'* rather than *'Public Health'*. For example, when making the distinction between his specialty and Psychology and Sociology, the teaching coordinator said, *'there is some of Public Health which is epidemiology, which is different and distinct'*.

The teaching coordinator felt the inclination to equate Public Health with epidemiology was inevitable, as this was the discipline in which most of them were trained:

> *I suppose it's where we all come from. We are all teaching basic epidemiological methods, study designs, ...screening programmes, how to evaluate things, very much I suppose quantitative methods.*

So teaching epidemiology was a central, and to some of its staff the only real function, of the Public Health Medicine group.

Some of the staff from Public Health Medicine connected epidemiology with other issues. The group's teaching coordinator saw the taking of a population approach as the key feature of both the epidemiological approach and the role of Public Health Medicine:

> *I think we are trying to give a slightly different perspective than the purely individual perspective, to try and give them a population perspective on health and disease and how they might study that, and interpret data around that.*

It was also linked by three staff with critical appraisal, being one of the principal tools they saw as essential in order for students to learn the skills of being critical and assessing evidence. For example, the teaching coordinator described the central features of Public Health Medicine:

We are trying to give them...through the disciplines of analytical epidemiology, the clinical science of evaluating what we do, whether it's clinicians or public health practitioners, to be more evaluative and critical..its making them more critical of the type of studies that you can appraise and use evidence.

Critical appraisal will be looked in its own right later.

Outside of Public Health Medicine, references to epidemiology were almost none existent. As we have said, it was mentioned in the medical curriculum book as being among the aims of the third and fifth year Psychiatry attachments, but not mentioned by either of the Psychiatry coordinators in interview.

Risk

Risk was a concept which appeared to be a familiar one to some respondents, especially in the Public Health Medicine group. It was also to a lesser extent familiar to the clinical staff, and taught in some of the clinical attachments.

As table F12 shows, risk was included in the aims for the term two, the Cardio-Pulmonary Systems course and there were two lectures on it in the term by the Public Health Medicine group. One of the group included it in his summary of the term, *'very much epidemiology study design, risk, randomised control trials and evidence-based medicine.'*

All the 6 respondents from Public Health Medicine interviewed used the word *'risk'*, an average of 4 times each. All agreed that the concepts of risk, and understanding risk factors were central to their discipline, and essential for students to know. Three of them mentioned the teaching of risk as among their teaching aims, and all said they taught about it. At times they set risk alongside other related concepts, and at others used it as a subset of one or other of them. For example, the Chair of the group saw risk as a subset of health promotion, naming *'risk factors'* as one of 5 component factors. The teaching coordinator saw teaching about *'risk factors'* as part of a cluster, naming it alongside with *'prevention...the principles of health promotion ...lifestyle...behaviour change...and screening'* as the content of what the group taught. Risk appeared to be taught by Public Health Medicine in a variety of ways, both as a concept in its own right and in relation to specific topics: those mentioned were smoking and the contraceptive pill.

Psychology also appeared to teach about risk. One of the coordinators mentioned *'identification of risk'* as part of a cluster of concepts they taught, which included *'medicine as more than about curing disease..larger social factors ..get away from victim blaming.'* A teacher of Psychology delivered a specific lecture, already briefly mentioned, which had as its theme *'cardio-vascular disease is a behavioural disorder'*. He gave an account of its contents, which he said involved a systematic trawl through *'11 risk factors'* to *'assess their*

relative importance' and recalled 8 of them in the interview:

> *...smoking, age, cholesterol levels, blood pressure, obesity, sedenterism.. Type A personality, socio-economic causes, psychological stress, (very poor work but I speculate about intervening physiological pathways)....*

5 of the clinical attachments appeared to touch, albeit lightly, on the concept of 'risk'. The third year Psychiatry attachment had as one of its written aims that students '*learn to assess risks of suicide and deliberate self harm'*, while the fifth year Psychiatry attachment was said by the coordinator to teach about the '*assessment of risk*'. In interview, the coordinator of the Obstetrics and Gynaecology attachment said that it looked at prevention in relation to HRT *'benefit risk type discussion*', while the coordinator of the Eye attachment mentioned '*children at risk of getting, say, squints*', and the coordinator of Dermatology said they looked at *'exposure risk*s' for skin cancer.

So, risk made some brief appearances in all parts of the medical curriculum.

Healthy public policy

As we have seen, two members of staff from Public Health Medicine, the Chair and the specialist in health promotion were also keen on healthy public policy, and the specialist mentioned the issue in her lecture on health promotion. They saw it as a cornerstone of health promotion, with the Chair describing it as, '*creating an environment in which it is easier to be healthy and to live a healthy lifestyle and so on'*. The teaching coordinator, although not apparently connecting the issue with health promotion, also expressed a strong interest in healthy public policy, which he summarised as:

> *the frame work where there are regulatory measures, there are fiscal measures, there are incentives and disincentives you can build into the way that society is structured.*

This coordinator said that he would like to expand the teaching in this area, saying, '*that is one of the areas of development...I plan to make sure that we are at least covering that*'. It was clear however that it was not something many in the group had yet taught much about, judging by the fact that his statements were all in the future or the conditional tense:

> *we are going to expand that with some work on healthy public policy... we don't have a lot of time in curriculum but I think we need to* ..(take) *an example like smoking, and looking at things like fiscal measures and regulations and so on. Its about what doctors can do, and probably don't do as well as could do....we do touch on that but I think it would be worth spending a little more time on respiratory illness, the control of traffic pollution...*

As table F11 indicates, the Sociology course contained lectures on health policy issues in

term 5. The coordinator of the course indicated that this was a new development '*we now have a much more explicit health policy statement on the course that we haven't had before*'. He said this had come about *'more by accident than design*' because a colleague in a sister department of Health Policy Studies had decided that '*she didn't want to teach over there,* ' and had therefore decided to teach the medical students.

Apart from this, there were no further comments about *'healthy public policy'*, under that specific title, although the issues involved clearly overlap others that have been looked at already in relation to health, health promotion and prevention, and on which, as we had seen, several staff made comments.

PSYCHOLOGICAL PERSPECTIVES AND ISSUES

- ***This thesis will explore the teaching of psychological issues in the medical curriculum, including looking at whether the medical curriculum taught about health related behaviour or behaviour change, and staff attitudes to this issue.***

Psychological perspectives and issues in the course as a whole

Table F13 summarises coverage of psychological perspectives and issues in the medical curriculum. In many ways work in Psychology parallelled work on social aspects, and often the two areas were grouped together under the heading *'psycho-social'*. The table shows that psychological aspects were mentioned in the medical curriculum book in relation to 13 of the 38 course elements. Like social issues, the presence of psychological aspects was strongest in the basic science elements where they were mentioned orally or in writing in relation to: the course as a whole; the basic sciences as a whole; the Foundation course; all 5 of the systems courses; Psychology; Public Health Medicine; and the Scientific Basis of Medicine course. Mentions in relation to the clinical elements were few, with only 4 courses mentioning '*psychological'* aspects specifically, orally or in writing. However, like social aspects, psychological aspects can be seen as being implied by the holistic approach of many of the clinical courses, and also as having a focus on patient centredness and communication, all of which are issues that will be looked at later in this chapter.

Teaching psychological perspectives and issues in Psychology

All the specific references to '*psychological*' perspectives and issues in the basic sciences appeared to refer to the work of the Psychology group, and so it is to their course that we turn first to unpack the aims and content of what was taught.

As with the Sociology course, there was, to judge from the titles, much overlap between the lectures that were listed as constituting the Psychology programme and the central concerns

Table F13 ***'Psychological perspectives and issues'*** **in the medical curriculum**[1]

	In medical curriculum book	In outline of Psychology course Lectures : (1 hour unless otherwise stated)	According to course coordinator staff in interview (negative instances in brackets)
Course as a whole	Aims *'to provide knowledge and understanding of:* *-human relationships in the context of the family, community and society, and the interaction between human beings and their environment'*		
BASIC SCIENCES		See below	Medical education coordinator said the basic sciences were taught by, among others, psycho-social scientists, and *'designed to help students get an integrated view'*.
Term 1 Foundation	*'Introduces the psychosocial sciences'* Aim *'to understand the range of factors, physical, psychological and social that can result in illness'*	'*Symptoms and their meaning*' (2 hours)	
Term 2 Cardio-Pulmonary	Objective *'understand the multi-factoral nature of disease'*	'*Cardio-vascular health*' '*Health belief model*' Practical on *'Smoking health education materials'*	
Term 3 Locomotor	Aim *'to consider the factors that influence ...development and health experience*'	*'Child Development'* (6 hours)	
Term 4 Nervous	'*Psycho-social'* listed among 9 *'sciences'* taught	*'Pain*' (2 hours) *'Black Schizophrenia*'	Talked of integration of psycho-social issues in the case studies
Term 5		'*Sexual health'* (4 hours lectures, 4 hours tutorials)	

Term 6 Gastro		No psychology teaching	Talked of integration of the psycho-social sciences in case studies
Psychology[2]	See separate column	See above	Said aims were to help students:
Public Health[2]			Health promotion lecture covered psychological influences on health, behaviour change, 'stages of change' model.
Sociology[2]	Some overlap of content with sociological issues: see table F11		
SBOM (year 3)	Aim *'to integrate the basic scientific knowledge acquired in the first two years into a clinical context'*		

CLINICAL COURSES	**In medical curriculum book[4]**	**According to course coordinator staff in interview (negative instances in brackets)**
EPC PMC	Aim *'to illustrate the ways in which psychological, sociological and physical factors may all interact and contribute to illness'*	
Clinical attach Years 3 and 4	Aim *'to reinforce the basic biological and psycho-social sciences which were taught in the first two years'*	Appeared implicitly, through the notions of 'holism' 'patient centredness' and 'communication' (see tables F15 - F18)
CFC	Aim (students be) *able to assess psychological well being'*	
PMC		Chair saw group as having '*integrative focus'* with psycho-social sciences Very keen to teach patient centredness and communication skills, including exploring patient's beliefs and understandings
Palliative Care	Aim '*understand the range of psycho-social issues for patients and their families'*	

Project		If student chooses it
O&G	Aim (students) *'become familiar with the social and psychological factors in human reproduction'*	
Total (from 38 elements)[3]	13	8

Notes

1. This table only notes positive instances. If a column is blank, or a course is not listed, it can be assumed that the entry would have been negative.
2. As Public Health Medicine, Psychology and Sociology did not have an entry in the medical curriculum book, their course outlines have been used instead.
3. *'38 elements'* refers to all the categories used for this particular analysis, which were the 31 courses, the course as a whole, first and second years, the third and fourth year, the fifth year, and Public Health Medicine, Psychology and Sociology.

of health promotion, and in particular: *'sexual health; 'child development'*; *'cardio-vascular health*; *'health belief model'*; and *'smoking health education material'*.

Like the coordinator of Sociology, all three psychologists said that they did not aim to teach medical students to be psychologists, or even aim to convey any particular psychological content. They all said they wanted students to see the relevance of a psychological perspective for their clinical practice as doctors and respect Psychology as a science, of equal validity and value to the natural sciences they were studying. The teaching coordinator echoed sentiments expressed by all three when he said:

> *And what I would like to be able to achieve is getting into the medical students thinking about the information on which they are going to draw to develop their technical practice and their clinical work, to realise that psychological research both in terms of it's empirical findings and studies and also in terms of it's theoretical formulations, is a valuable and useful resource for them to draw upon. I think the specific content of what one gets over there, is a certain sense of secondary.....as long as we can get over that Psychology is a valuable, important science in the same way that their Micro-Biology or their Physiology is, and that we have testable theories, then that is what I hope we are able to achieve.*

Or, as another of them expressed this aim '*to understand it's not all common sense: there is a scientific rationale for it and it has equal weight and status as any of the other scientific subjects they have*'.

Theory was clearly of great importance to this group. One of the teachers said that a further aim of their teaching was to impress upon students that there were no clear answers, but instead a range of models to choose from, and that all actions have an implicit model. She contrasted that with the 'taken for granted' approach of medicine:

> *there isn't often one right answer or right model and that people, even if they don't explicitly think they are working to model do have implicit assumptions ... to actually realise that because within medicine explicit models are often not made apparent.*

As we have seen, this teacher also linked Psychology with social issues, and saw both of these disciplines as combining to convey a *'holistic*' perspective, which she summarised, pithily:

> *I hate the term 'holistically' because I think it's so over used, but I try to help the students realise that people are more than a bag of bones.*

Describing a case study she had jointly written with a clinician, she talked of how they attempted to inject some humanity and social context into the impersonal world of medical education:

> *we spend a lot of time painting a picture of what this person is, where they live, the kind of surroundings they are living in and the economic situation they are in, and that is what I want them to see, not a kind of person stretched out on a bed in a hospital, but real live people*

All three interviewed saw Psychology as overlapping naturally and comfortably with health promotion, and nominated many topics on which the two disciplines shared an interest. Some of these teaching topics have already been noted in earlier sections on *'health promotion'* and *'prevention'*. To recap, this group taught about prevention, risk factors, social factors, 'the limited usefulness of telling people what to do' (which they called *'the health-behaviour gap'*); the prevention of smoking and smoking cessation (on which the group taught a practical); and what one called *'cardio-vascular disease as a behavioural disorder'*, looking at how to prevent cardio-vascular disease through diet, exercise and stress reduction. Other topics also mentioned as being taught by Psychology that are of interest to health promotion included *'the health belief model'* and two attempts to interest students in issues to do with their own health. One Psychology teacher said he tried to persuade students to look after themselves as future *'role models* for patients, while another said that:

> *I mean certainly we try to use the examples that are related to them.* (Name)'s *work about sexual health was very, very popular. They did tend to like what happened in Africa rather more than what happened in Southampton, but he tried to introduce this is an issue for young people where ever they are.*

The issue of the students' own health will be looked at in more detail later.

A brief extract from one Psychology teacher's account of what they were aiming at may illustrate the overlap of their language and terminology with that of health promotion. She said they were trying to get students:

> *to think about medicine as more than about curing disease, to actually saying how can we go beyond that, and look at identification of risk, what are larger social factors, the Black report and all those sort of things, and to get away from victim blaming.*

So, as we said when we looked at the teaching of Sociology, it seems that many of the most central social issues that were of concern to health promotion were also to be found within the teaching of the Psychology course. (It may be recalled too, that the lecture in health promotion also covered some psychological issues, such as psychological influences on health, the influences on behaviour change, and the 'stages of change' model.) Again, it should be recognised that such inputs were very brief, constituting only 22 hours in all, spread over two years, although in the case of Psychology, all agreed that its individualistic insights and more 'scientific' approach were easier to assimilate into the surrounding

context of the rest of the medical curriculum than had been the case with the social orientation of Sociology. Again, the issue of how this discipline was viewed by the rest of the medical school is one to which we shall return.

Behaviour

The rationale chapter indicated that behaviour and behaviour change are of particular interest to health promotion.

- ***This thesis will explore whether the medical curriculum taught about health related behaviour or behaviour change, and staff attitudes to this issue.***

As the concept is most often associated with Psychology, we will look at it here. The data that relate to this issue will be drawn from several preceding sections, so some recapping will be necessary.

Work on behaviour was mostly mentioned as occurring in the Cardio-Pulmonary Systems course in term two of the first year. The medical curriculum booklet included *'the factors which motivate people into adopting healthy behaviour patterns'* in its objectives in the medical curriculum book, while the name of the overall theme that was used to organise the teaching of the psycho-social and Public Health Medicine component of the term was *'changing health behaviours'*. Behaviour change was reported as being mentioned in the Psychology, Sociology and Public Health Medicine lectures, although none of them had the word *'behaviour'* in their title. A teacher of Psychology delivered a specific lecture, already briefly mentioned, which had as its theme *'cardio-vascular disease is a behavioural disorder'*. Staff from all three disciplines, as well as Primary Medical Care all said they taught the students 'the limited usefulness of telling people what to do' as a way of changing their behaviour.

The lecture on health promotion given in term two by the specialist lecturer include references to the 'stages of change'. The 'stages of change' theory appeared from the remarks of one teacher of Primary Medical Care, to have been picked up on by at least some medical students, as he reported that they used this model in their third year seminar presentations on health promotion.

So, it would appear that behaviour was mentioned in a range of places and in connection with a range of issues, although not the subject of specific teaching. It could however that more teaching was taking place on this issue than emerged from the interviews, but that the rather indirect interview questions used did not uncover it.

PERCEPTIONS OF PSYCHO-SOCIAL SCIENCE TEACHING

Rationale for looking at the psycho-social sciences together

So far in this chapter we have looked at the two psycho-social sciences separately, as this was how the staff who taught them viewed them. However, perhaps because of the attempt at integration, many of the medical staff appeared to find it difficult to distinguish between Sociology and Psychology, and the two disciplines shared many issues, and particularly problems, in common. So we shall now look at them together, as *'the psycho-social sciences'*.

The psycho-social sciences as a problem

It was clear from almost all of the interviews that there was a very widespread view that the teaching of the psycho-social sciences constituted a problem. It was a matter on which staff appeared to feel strongly, on which they expressed wide range of complex attitudes, and which clearly affected their attitudes to a range of issues that are central to this thesis. So, staff perceptions of the problems of the psycho-social sciences will be covered in some detail in this section.

As much of what staff said was critical of other colleagues, the sections that follow will be more 'anonymatised' than other sections, and will identify staff by function (e.g. coordinator of a systems course) rather than by individual course or attachment, unless it seems particularly important to identify the specialty concerned and the comments being cited were descriptive rather than critical.

Integration between the psycho-social sciences and the rest of the curriculum

- ***This thesis will explore the issue of integration in the medical curriculum in question. This will include looking at whether the specialties that are most likely to teach health promotion were integrated into other courses.***

We have seen that each of the 6 terms had a 'psycho-social and Public Health Medicine' theme which was intended to provide a link to the system of the body that was the subject of that term's course. The overall coordinator of the medical curriculum was keen to emphasise that the intention was to integrate saying that the systems courses were *'taught by a combination of clinicians and scientists, social scientists, biological scientists'* working alongside one another, which, he said was *'designed to help students get an integrated view.'*

There were indeed a few positive examples of the integration of psycho-social perspectives

into the mainstream work of the basic science courses. The coordinator of the first two years, who was also the coordinator of the Foundation term, felt that in his own term the psycho-social sciences were well integrated: he mentioned in particular the assessment, where the term essays covered *'wider sociological and health educational'* aspects of medicine, as well as *'biological'* ones. Term four, the Neurology and Neuroendrocrine systems course, had attempted to include psycho-social perspectives into the *'integrative case studies'* they employed, which the coordinator thought had gone well. She herself was keen on psycho-social science, and particularly pleased to report that they had introduced some true/false Sociology questions into the term exam, which she thought gave a good message about its importance. The coordinator of term six, the Gastrointestinal and Lymphoreticular system, talked very positively about how the psycho-social sciences were integrated in that term. She said the psycho-social scientists contributed work on *'how people cope with being HIV positive'* and *'the occupational health aspects of cancer'*. She was very positive about the amount of effort and thought the psycho-social scientists had put into making their content relevant, which she felt had paid off:

> *my impression is that, for a while, it didn't work, for a while the psycho-social side of the course was independent from the course, but it seems now that there are less sessions and they do seem to be related. For example, there is an input into the cancer symposium, they consider the screening programmes and the basis of developing such a programme...psycho-social medicine is linked to the radiation biology course ..they do link quite well now. People have put a lot of effort into it, to actually try and make them more relevant, and if there isn't anything that is relevant to term six, it is removed.*

The coordinator of the Scientific Basic of Medicine course also mentioned some *'integrated teaching afternoons'*:

> *where they* (i.e. the students) *might have a pathologist, and somebody from one of the more psycho-social areas that jointly discuss aspects of a particular disease.*

However, outside of these few positive examples, most staff felt that there was a major problem of integration between the psycho-social sciences and the rest of the curriculum.

One of the overall coordinators saw the relationship of *'psycho-social science'* to the medical curriculum as a *'considerable problem'*. He felt that the psycho-social sciences were *'very much a bolt on extra'*. He disagreed with the view of all four of the psycho-social teachers interviewed who, as we have seen, thought that both the Sociology and Psychology groups taught only what was applied and relevant to medicine. This overall coordinator felt that, as none of those who taught psycho-social science were themselves medics, they *'have a particularly difficult job in actually seeing what it is that medical students should learn about'*, and that as a result the psycho-social scientists were only able

to teach their specialty in a 'pure' form:

> *Inevitably that means they just feel "Oh well, let's try and teach as much social science as we can within the curriculum time they allot us, when we'll try and make them into mini social scientists." That tends not to go down well with medical students and tends not to integrate well with the rest of the course.*

Some term coordinators also expressed concerns about the lack of integration of the psycho-social sciences into the rest of the term. One of the term coordinators saw the psycho-social science input as it was currently taught as irrelevant to the content of his course. He laid the blame for the lack of integration at the door of the psycho-social scientists, who he felt were too theoretical, and not prepared to put the necessary effort into integrating the examples they taught with the work of the mainstream curriculum:

> *There are so many case histories of elderly ladies with osteoporosis who are going to have to go home and have somebody to look after them, children with cystic fibrosis, where one could talk about sibling rivalry, and talk about anxieties that parents have with childrens' health, and lots of patients, paper patients who die, and obviously that brings in all the components of bereavement and grieving. There are so many opportunities on the course where Psychologists and Sociologists could join in, and when they do, what we get is a lecture on the 'Psychology of parenting', lots of references to some theory of something.*

Another coordinator felt especially strongly about the lack of integration:

> *I would almost go as far as to say I could almost be distraught at the thought that so much time can be spent on something which is picked up so little later on.*

One of the teachers of psycho-social science also felt there was something of a problem of integration as far as her colleagues were concerned. She thought that, because of her own background in the health services, she was unusual in being keen on collaboration with others and integration of the teaching of her subject into the everyday concerns of doctors: she felt that most of her colleagues were more interested in academic demarcation disputes:

> *a lot of my colleagues ...don't view it like that at all* (i.e. as in need of integration with mainstream medicine). *But you see most of them haven't worked in the Health Service and they don't think about it as an issue. So actually, disciplinary integrity is very important then to them...the differences, the demarcation lines between what is Psychology and what is Sociology and what is Public Health, is much more important.*

The overall coordinator, who saw the integration issue as *'a considerable problem'* was also keen to see more integration of a psycho-social perspective into the clinical years, and

saw it as particularly important that psycho-social issues were taught at the same time as the problems to which they related in practice occurred:

> *I think that the ideal for social science is that it should be taught in the clinical part of the course, and yet it is so difficult to arrange that that happens. Perhaps it's a bit of an oversimplification, but I think, a Japanese 'just in time' principle of industrial production works in education too. If you teach someone about something and then there's a three year gap before you come across the decisions. If you teach it just as they've actually hit the problem.....*

Even staff from Primary Medical Care, who were unusually sympathetic to psycho-social science, had concerns about the way the teaching was currently organised. One of them felt that there was no contact between what was coming up in psycho-social science lectures and what the students were experiencing in the rest of the course. She felt this made the, potentially highly appropriate, content appear irrelevant to the students:

> *unless we can get some flexibility between what comes up in the lectures and what students are actually experiencing and want to know about, we are not going to get anywhere. So we have got irrelevant content, not that there is anything wrong with it, it is just not felt as relevant, and then a whole lot of relevant questions coming up, which there is no way of getting information about at the moment.*

Three people suggested that positive efforts were being made to improve integration. One of the overall coordinators said:

> *We are in the middle of discussions with* (name) *who has particularly been in discussions with the Department of Social Science, and he has obviously been looking at their proposals. I think that perhaps we need to try and inform their plans a bit more than we've been able to in the past.*

Similarly the coordinator of one of the systems courses reported that now even more efforts were being made to integrate:

> *we're hopeful that it will* (integrate) *cause we've got* (name: new Chair in Psychology) *now who is going to come on to the term four working party, and he will get a grip on what goes on with the Psychology.*

Reported student attitudes to the psycho-social sciences

One member of staff, a coordinator of one of the clinical courses, said that students liked psycho-social issues, saying, *'they are also very receptive to that level of teaching, I can tell you that.'* However, he was the only person to express such unequivocally positive view. The belief that students did not value the psycho-social sciences tended to be shared by most staff who commented on the matter, whatever their personal evaluation of the worth of these subjects.

For example, a coordinator of one of the systems courses felt that psycho-social science was valuable, but that *'its quite a problem in terms of students not perceiving its value.'* Another coordinator also felt, more strongly, that *'psycho-social science'* was '*uniformly disliked by the students*', adding, '*I am not sure the students see the point of it at that stage; they can't pick up on it clearly'.*

One of the teachers of Psychology reported that he was *'horrified'* by the students' negative views of their Psychology teaching, expressed in their feedback forms:

> *it was really usually a disparaging set of comments about it's triviality, it's marginality as far as they were concerned. There also was some rather more cogent criticisms about repetition and lack of development within that teaching.*

Another teacher of Psychology had carried out the task of coordination for several years and claimed to have had a fairly refined idea of the extent of the problem. Her perception was that 20% of students currently actively liked the psycho-social teaching, and that this proportion had increased over the last few years, judging by the improvement in their essays and the numbers of students coming back to do their third year *'case-based essay*' and/or a fourth year project in a psycho-social science. She felt that 30% *'hated'* it, and '*are probably a lost cause'*, but 50% were *'indifferent'* at the moment and *'that's where we really need to work on*'.

Influence of other pressures on students

One of the psycho-social scientists saw the problem of student antipathy as multi-faceted, but felt that one reason for it was that the students were so overloaded with medical facts to learn that even those who were interested felt they could not afford to *'waste time'* on the psycho-social sciences, for fear of failing. He remarked that for many students who had been used to being the academic elite in their secondary schools, Medical School provided their first experience of finding learning difficult, which he said they found *'devastating,'* and which he said *'reinforces this need to concentrate on jumping over the next hurdle'.* Despite the fact that he had to eject some of them out of his lectures, for *'throwing paper aeroplanes'* this coordinator felt generally sorry for what he saw as these '*downtrodden*' students, seeing them as:

> *very much exposed to the mass education sausage machine...seeing themselves as the sort of the lowest of the pecking order and only too grateful for people to sit down and talk with them.*

Several staff mentioned the influence of the nature of the assessment on student attitudes. One psycho-social scientist felt that the students were being taught a '*conception of being a proper doctor as embedded in learning lots and lots about the body'.* She reported that

many students knew there is more to medicine than this, but that their fear of failing the assessments drove them to spend their time cramming facts:

> *if you actually talk with them they will say, "Well actually, no, it is important. Patients do have minds, it is important that we can negotiate with them properly and so on". But when it comes to the crunch, "Shall I read this chapter, or shall I learn this extra fact on page 6 of my anatomy book?" Because they know they will get a spotter; they get those every term.*

She empathised with their pragmatic choice, *'I think in their position that is what I would do too.'*

Three staff reported that psycho-social science was now assessed, and that this was permeating down the years as *'part of the folk law'*. All three said that they felt that this was giving the area more status in students' eyes.

Attitude of mainstream medicine

5 staff, including all 4 psycho-social scientists, traced the antipathy of students to psycho-social science back to the staff who taught them other subjects. A coordinator of one of the systems courses, who was sympathetic to the psycho-social sciences, was nevertheless aware of the negative attitudes of some other staff:

> *that's coming down often from other academics, its being fed in by other people. The ones with the true medical model will disparage that 'lefty pinko stuff'.*

All 4 of the psycho-social staff interviewed agreed that they were treated with respect in their face to face contacts with the 'mainstream' basic scientists and clinicians, but all felt that behind the scenes, attitudes were much less positive. For example, when asked why there was not more integration between what he did and what the clinicians did, one teacher evoked the anthropological concept of 'tribes':

> *you just can't integrate. In practice there are hidden agendas, there are rival territories, there is contempt, disrespect and envy.*

One teacher of Psychology confirmed that in her experience students were indeed often exposed to negative comments about her subject:

> *the kind of commentary that, "Ooh you poor souls, you have got Psychology. Well you needn't bother to go to that lecture".*

She felt this was placing *'unhealthy tensions'* on the medical students, who were *'driven to take sides'*.

Another psycho-social scientist felt that medical colleagues expressed similar hostility towards Sociology:

> *you are up against the culture of Medical Schools and medicine, and I think there are some people over there who have a very hostile, anti, or 'its not relevant to being a good surgeon' kind of attitude.*

He too had a story to tell about overhearing a colleague tell students who were due at a lecture on psycho-social sciences, *'"don't bother with that, I've got something really quite interesting you would like to come and have a look at"'*. He said this *'rather summed up my feelings of the relationship with the Medical School'*. He felt that anything that was not mainstream was marginalised in the Medical School:

> *It seems to me that anything that is not relatively hard core, about bodies and things, is highly marginal, in terms of the core curriculum, in terms of the perceptions of people who contribute to things outside that hard core, and indeed to the attitudes of some of the people in the Medical School.*

He saw this marginalisation as built into the structure of the way the curriculum was designed, where psycho-social science had to weave its way through what he saw as an inappropriate structure, designed around the physical systems of the body.

Two psycho-social science teachers remarked that they found it significant that none of the psycho-social scientists had been informed of an imminent visit by the General Medical Council, and then asked at the last minute to produce a poster. As one said, *'they say it's a clerical error, but ....'*

One of the psycho-social science teachers thought that the reputation the Medical School had for being keen on psycho-social science was quite unwarranted, remarking, *'maybe when it was built, but clearly not in my experience'*. He felt that other medical schools were now much more supportive of psycho-social science, and that the early efforts the Medical School had made in this direction were now getting in the way of change, by inducing an air of complacency:

> *it's part of the culture, you see, because they think they've got it cracked. Well, they may have done all those years ago.*

Looking at it from the other side of the fence, a coordinator of one of the systems courses agreed there was an antipathy of mainstream staff towards psycho-social science, but felt it was justified. He saw other staff as resenting the amount of time the psycho-social scientists had won for their integrated course, in the process of which many other subjects had their time reduced, which created a great deal of bad feeling. The fact that psycho-social science

was, as he saw it, now badly taught added insult to injury. Such negative attitudes were expressed even more strongly by another coordinator, who felt very strongly that psycho-social teaching was a complete waste of valuable time:

> *One has one's teeth into it, because one is aware the preciousness of time, and they seem to have at the moment, what seems a disproportionate amount of time. ....I would almost go as far as to say could almost be totally removed, unless someone gets their act together extremely sharply. One is conscious of the fact that I think our period of teaching has been reduced according to the new rulings on this, but I am not sure if their's has at all, and we are fully conscious of the fact that they are occupying vast areas of time and nothing very much seems to happen in them.*

Clash of cultures

Several respondents talked in terms of a *'cultural clash'* between psycho-social science and mainstream medicine, in which the former invariably lost. The conception of the rift as in some sense *'tribal'*, using that term, was expressed by three staff, from both clinical medicine and the psycho-social sciences. For example, one of the overall coordinators of medical education, himself a medical doctor, felt that the medical students' objections to psycho-social science was exemplified in the use of specialised languages:

> *students have identified very early on as part of a tribe, and then they meet someone like me, with the stethoscope hanging out of my pocket and pictures of patients, who starts talking about all the things that they think medicine consists of, yes they respond to that, and identify with it. When somebody comes and starts to talk to them, using terminology, jargon if you like, which they recognise as meaning not belonging to medicine, that's someone else's job; it tends to excite suspicion.*

One psycho-social scientist agreed that the problem was in some sense '*tribal'*. He saw the students as mentally preparing for their future role as '*the elite which they are going to be...triple bypass instant success surgeons'*. He thought that this induced in them an attitude of '*esprit de corps*' which could turn nasty when they were faced with members of an 'out' group:

> (the students' attitude) *degenerates into the hunting pack activity, the way in which they treat female Sociology lecturers for example.*

There was some disagreement about when in the students' career this clash began. Two of the psycho-social science teachers felt it had its roots in the school, in the science based 'A' levels the students had studied, in which *'part of that culture has been to marginalise the arts and the humanities'* as one of them put it. However, congruent with her belief that hostile attitudes originated in medical staff, one of these teachers also pondered on the fact that students did not appear to have this attitude on arrival, when *'they actually are quite interested in what Psychology has to offer'*. One of the overall coordinators was clear in her

belief that the problem was very much created at Medical School: her perception was that students arrived *'fantastically fired up and interested'* about '*all sorts of things*' but that the '*culture of the preclinical*' rapidly *'got to them':*

> *the culture tells them that what counts is knowing about cells and nuclei, and not about the structure of the NHS and that sort of stuff. Very quickly they develop the perception that it's actually second rate, it doesn't count somehow... even though, they know they get tested on it, it doesn't count.*

She felt that in general the students were *'terribly bored'* by all the basic sciences of the first two years, including the biological sciences, but that their attitude to *'physiology and stuff'* was '*they know its important, they've got to know it, so they put up with it.*' Seeing the psycho-social sciences as unimportant, they allowed their boredom to turn into antipathy.

Different ways of thinking/ epistemologies

We have already noted that one of the teachers of Psychology said that a key goal was to help students realise that there are no right or wrong answers, just different models for action, each with different types of consequence, but that such an approach went against the approach of medicine '*where implicit models are often not made apparent*'.

10 staff commented on the differences in the ways of thinking between the psycho-social sciences and more mainstream aspects of medicine. Three staff used the term '*epistemologies*' when describing this clash. Words used to describe the psycho-social science epistemology tended to include '*interpretive*' and '*reflective*', while that of medicine tended to be described as '*positivist*' and '*facts based*'.

One of the teachers of psycho-social science thought that part of the problem was that doctors do not appreciate that the psycho-social sciences involve not just 'other facts' but different 'ways of knowing'. He felt that doctors think *'a social scientist can answer the question they know now....well I'm sorry it's not really like that and I think it is hard.*' Talking in the context of attempting joint research with medicine, he added:

> *I have done and do do work that collaborates with medics of one kind or another but you have to put investment into talking to people and building up those kind of relationships from the ground up before you get there. What you can't be is some kind of resource that they can ring up and say 'I've got this study on childhood asthma, give me an appropriate methodology to build in some dimensional of social class'*

One psycho-social scientist felt that there were fundamental and confusing differences in *'styles of teaching and basic epistemology'* between the psycho-social sciences, which he saw as essentially concerned with theories, probabilities and good arguments, and the sciences that underlie medicine, where, at undergraduate level at least, teachers talked just

about facts. He felt most of his medical colleagues, *'don't even realise that there is a difference'* and thus failed to recognise the problem or help students with it. One who did appear to realise there was a problem was the coordinator of Geriatric Medicine, who was generally supportive of a psycho-social science way of thinking. He felt that part of the reason why medical students do not like psycho-social science was because its slow reflectiveness did not fit with their preferred pacey style of learning:

> *medical students, in general, are very used to taking on information at high rates of information flow, and the bits going in quick, quick, quick. So they are used to taking on board a lot of information in a very short time, and then probably not being very reflective about it. Whereas a lot social science teaching, in areas like Psychology or anthropology, would be completely the opposite, where you are not trying to batter in a lot of facts very quickly, we are trying to encourage people to reflect on things.*

It was interesting that he used the pronoun *'we'* when referring to *'social science areas'*, indicating perhaps his personal identification with this way of thinking. This coordinator thought that medical students might be a bit young to be reflective:

> *social work students have to be mature, or maturer, which you are by definition, or you are not allowed to do the course. So it may be a bit hard to ask 18 or 19 year olds to reflect on what an 89 year old might or might not be perceiving.*

One of the teachers from Primary Medical Care agreed, and thought that it may be that such things were better left to the postgraduate level:

> *I think there is a real theoretical question there, about when is the right time... maybe that it is the pre-registration year where it should be being solved.*

One of the teachers in Public Health Medicine agreed with the coordinator of Geriatric Medicine that the psycho-social sciences were more reflective which he felt was '*a concept that's very foreign to most doctors'*, including himself, '*people like me are trained, are picked, and have got here, because we are good at reciting lists*'.

Several staff remarked that this clash of epistemologies was highly confusing for students. One of the teachers of Public Health Medicine commented that '*the vast majority of the rest of the course is the positivist scientific approach'* and illustrated the problem this gave the students with a telling, real life, example:

> *one student said to me, one of my tutees, nice lad, very bright, "I really don't want to sit and hear what one person said about this theory, and then another one said, and this bloke Freud said, and that bloke said ... I want to know what the facts are. Who needs to know what the arguments and the pros and cons and the evidence has been? That's irrelevant" They do find that very hard.*

Another of the teachers in Public Health Medicine identified Sociology in particular with discursive and abstract ways of thinking, and felt that it was particularly likely to be seen as different from the positivist and empiricist ways of thinking taught in the mainstream curriculum:

> *medical students are a breed apart you know, they are this sort of minimalist positivists, and they want facts, overheads that have '6 facts about', and you don't get that from the Sociologists.*

Psycho-social science as common sense

Several staff felt that a particular aspect of the clash between the two cultures and epistemologies was the dismissal of the ways of thinking of psycho-social science by staff and students as commonsense.

For example, one teacher of psycho-social science said that one reason why '*overstretched*' students saw the psycho-social sciences, as '*eminently missable*' was that they saw them as common sense, the *'oh I know that'*, syndrome as she put it. She felt that one problem was that psychological language and everyday language overlap, so that students tended to dismiss it as *'all common sense'*. One of the overall coordinators summed up what she saw as the students' attitude, '*it's sort of interesting, but really you can read it in the Guardian'*, and felt that therefore the pressure of all those new medical facts that were not seen as common sense squeezed out psycho-social science. One of the teachers from Public Health Medicine contrasted this commonsense knowledge with *'all the gee-whiz scientific stuff they are learning'*.

As we have seen, the coordinator of the Geriatric Medicine course had organised sessions on psychological issues, taught by social work staff. He also reported that students tended to see this as '*all common sense*'. As he personally was keen on these sessions, he dismissed the student antipathy to them as *'tough'*, adding:

> *they say "It's obvious, and we don't really see the point of knowing about that kind of thing." Well, I think that is a kind of area where, I am afraid, they are just going to have to put up with it.*

However at least one member of staff shared the reported students' view of psycho-social science as common sense, and a low level activity. One of the coordinators from the first two years, a clinician, and the one who had expressed strong annoyance about the amount of time given to the psycho-social sciences felt that, in so far as highlighting psycho-social perspectives had any merit, it was the kind of obvious and easy thing that a half way decent clinician would do anyway:

I mean, anyone can pick up a psycho-social issue in one sense...if you are on a ward round and you have a patient whose problems are, let's say to a considerable extent, of a social nature or even psychological, it's not hard to point that out, even if not by the bedside, shortly after...so if ever there was a bit of life you can pick up as you went along, I would have thought that was one of them.

Conflicting teaching methods

Some staff saw the clash between the psycho-social sciences and medicine as exacerbated by the different, and some felt inappropriate, teaching styles they saw as employed by those who taught the psycho-social sciences. One of the teachers of Public Health Medicine felt that psycho-social scientists, by virtue of their own education, did not possess the necessarily brutal and flamboyant approach to which medical students responded:

the style of teaching in Sociology is very different from the style of teaching in Medicine. I do not think the Sociologists are educationally equipped for what (name) *will constantly refer to as 'the bear pit'. 150 students, and holding, grabbing their attention for 45 minutes and make it exciting and interesting and holding them. They just can't do it; they haven't had the training I guess, which is often on-the-job training, and so they do lose the attention of the students. They have a discursive style of lecturing and argument, the kind of thing I was saying earlier: 'On the one hand Freud said this, on the other hand Adler said this'. You can't do that; you have got to be able to grab them and make it relevant to them.*

He felt the ability to make the theory relevant to the context of medicine was absolutely crucial:

(you have to) *keep referring back. I play all sorts of games and I am quite shameless about it. If I feel I'm losing them then I will remind them; I'll tell them an anecdote about when I was a doctor. Of course, I can do that. I can't see why Sociologists can't say, "My GP did such and such". You don't have to be it, but you have to keep relating it to the business of being a doctor.*

Another teacher from Public Health Medicine felt that medics *'are very visually clued'* and responded well to lectures that used OHPs with bullet points, whereas the teaching style of psycho-social science was more discursive and abstract. To illustrate his point he described a Sociology lecture in another department he had attended out of interest, and in which he had felt lost:

somebody just got up and read an erudite essay for about forty five minutes, without any visual clues or a little list. They just talked about this 'ism' and that 'ism', and I was a sentence behind all the time, and I didn't really understand the key points.

Psychology more popular than Sociology

Some staff did not distinguish between Psychology and Sociology, talking instead of *'social science'* or *'psycho-social science'*. However many did, and all 10 who spoke on the subject agreed that, in so far as students and staff themselves distinguished them, Psychology was better thought of by students and medical staff than was Sociology.

We have already seen that staff from both Sociology and Psychology agreed that the social or *'collectivist'* approach of Sociology was more at odds with the medical perspective than was the individualist approach of Psychology. The coordinator of Sociology was clear that his subject was not popular with students, regardless of who taught it. He remarked wryly that his score on the student assessment sheet had been *'mediocre'* and that of a Professor of Medicine *'good,'* when both had in fact been on sabbatical leave in the relevant term and not taught at all.

We have already seen that one teacher from Public Health Medicine thought that Sociology was particularly likely to be thought to be characterised by the reflective and abstract ways of thinking which students and mainstream doctors tended to find difficult to reconcile with the positivist and concrete ways in which they tended to view the world.

There was one example of a positive comment on the teaching of Sociology from outside of the psycho-social scientists themselves, and even then it was clear that the Sociology lecturer concerned did not feel positive about it. One of the systems course coordinators said:

> *The Sociology is fine as far as I can tell.* (Name) *gets a bit panicked about coming to do the medics, his heart sinks, but the stuff on families and carers is quite legitimate.*

In contrast, 6 staff, three of them basic scientists, said that students positively liked Psychology teaching. The consensus was that the psycho-social topics which went down well tended to be taught by Psychologists, and included sex education, sexual behaviour, HIV AIDS, and developmental Psychology. For example, one of the systems course coordinators said:

> *the psycho social course doesn't always get a good press, but when we do our assessments the Psychology element by* (named lecturer who spoke on child development) *absolutely sweeps the floor with scores.*

A teacher of Psychology wondered whether one aspect of the problem was that most of the Sociologists were women:

> *they don't like being told things by females, unless they are conspicuously*

successful young consultants.

Staff ambivalence about teaching medical students

We have seen that hostility was described as emanating from students towards psycho-social teaching. It may be recalled that the lecture theatre was reportedly described by one person as a *'bear pit'*, while two others reported that paper aeroplanes were sometimes thrown at psycho-social scientists, and one reported that female Sociology lecturers were taunted. It seemed that coping with this level of aggression sometimes got too much for some psycho-social teachers, as the coordinator of the first two years reported:

> *we have even had examples of where staff* (psycho-social scientists) *had actually refused to teach again, because they had a one session that was disastrous, and they have said "I am not doing it again."*

Given also their feelings of alienation from mainstream medicine, it is perhaps not surprising that all 4 of the psycho-social staff interviewed, as well, it may be recalled, as the specialist in health promotion, talked of ambivalence towards teaching medical students. The coordinator of Sociology said that '*in general the Department is supportive and committed to teaching medical students'*, but he wondered why, and concluded that it was partly for academic reasons '*because people like me think that, for Sociology to have any kind of credence, we must contribute to areas like that,'* and partly '*pragmatic in that we get FTE's'* ('full time equivalents', i.e. fees for the students on a pro rata basis). However a teacher of Psychology perceived the Sociologists as not putting in as much time to organising their teaching of medical students as did the Psychologists, which he appeared to partly envy and partly find regrettable:

> *its partly because Sociology, probably very wisely, doesn't waste its important research time fiddling around with timetables, and I think we shouldn't, quite honestly. There's nothing in it is for us except some money, and we can't even find out how much that is..... Its a shame that they don't get a coherent, engagingly delivered and very persuasive set of sociological analyses.*

Another teacher of Psychology felt that the low morale of those teaching psycho-social science to medical students was a national problem, judging by the number of complaints she heard voiced at conferences:

> *I have been to conferences which are about teaching the psycho social sciences, but they seem to be sort of massive 'moan and groan' sessions.*

Should staff who teach psycho-social science be inside or outside the Medical School?
A large gap appeared to exist between the views of the 4 psycho-social scientists interviewed and all the others, 10 in all, who voiced an opinion on the subject, about where staff who taught psycho-social topics should be located. All the psycho-social staff themselves were clear that they thought it preferable that such staff should remain located in their specialist departments: they feared else that such staff would become isolated, marginalised or, as one put it, *'go native'*, all of which they saw as bad both for the quality of the teaching and the career prospects of the people concerned. Two said they had experience of this happening to psycho-social science colleagues based in other medical schools.

In contrast, all the other 10 staff who commented on the matter, felt that the separation of the staff who taught these topics, professionally and geographically from those in the rest of the Medical School, was a major part of the problem. All wanted to see a shift of the teaching of psycho-social science into the Medical School.

For some, it was a matter of bringing specialist psycho-social staff into the medical school. For example, two staff in Public Health wanted to see what one described as, *'medical Sociologists, health Psychologists, who are part of their research team, where you are already working with them.'* One of the teachers from Public Health Medicine said that experience of the *'London Medical Schools'* demonstrated the academic value of physical integration:

> *if you want to be a good health service researcher in the Social Sciences you have to live amongst the medics, and the health service people, and the therapists, and the nurses, and see how it ticks, and actually be in there, and get involved in their questions. Good health Sociology and medical Sociology at the moment tends not to be the distanced theory and the Sociology of knowledge stuff I used to be interested in: its about Health Services' function, and what the question are, and what the problems are there, and you have to be in there to do it. So there are actually good intellectual reasons for being part of the Faculty.*

He was aware of the 'going native' argument, but felt this problem could be solved by having a small group of psycho-social scientists *'together for warmth and mutual comfort'*, but based in the Medical School.

Another teacher from Public Health Medicine pointed out that many of the staff who were already in their group were in any case psycho-social scientists, not doctors, *'there are more non medics in this department than there are medics'*, so he felt that a good precedent had been set.

If they were not to achieve this relocation, one of the teachers from Public Health Medicine

agreed with the view of one of the overall coordinators, which we have already noted, that the Medical School should specify much more closely what they wanted from the psycho-social scientists:

> *Or that we have a much stronger contractual relationship with them, and specify exactly what it is we want them to teach, and sort of quality assure it, and if they are not teaching it tell them so and change it rather than say "Well we know Sociology is important, and you know about Sociology, so you come and teach us what you think", which is the way is has been so far. So by some means or another, we have to get more control over how the Sociology is taught and what Sociology is taught and how it fits in.*

He felt that the psycho-social scientists, particularly the Sociologists, were '*paranoid*' about being '*taken over*' by medicine:

> *The Sociologists, Social Sciences, are pretty paranoid about the medical profession, and they therefore find it pretty difficult to work alongside and work with us, because they always think we are trying to take them over, and that can become a self-fulfilling prophecy unfortunately. Having said that I think the person teaching Sociology tries very hard to fit in with us.*

To some extent any such *'paranoia'* on the part of the psycho-social scientists may have had some justification, as 5 other staff went so far as to suggest that responsibility in this area should be taken out of specialist hands, and psycho-social aspects taught by doctors. Three said that the psycho-social scientists appeared not to actually like this teaching, for example, the coordinator of the first two years said they saw teaching *'as a chore: they don't identify with medical students'*. One of the systems course coordinators, the one who felt that the *'psycho-social scientists'* teaching was *'too theoretical'*, contrasted the experience of other medical schools where he reported that such teaching was carried out by *'real clinicians'* talking about *'real problems'*:

> *In Newcastle there is a guy called* (name) *who runs their course, their psycho-social, whatever you want to call it, is taught mainly by Child Health. Its taught by real physicians, who talk about real problems and real patients and how they deal with these things, and how they deal with anxieties and what have you.*

One of the overall coordinators also felt that students might accept psycho-social science if it was taught by doctors:

> *I do think there's a big problem with street cred ...if you have medics going in there telling them stuff about Sociology they'll accept it...but if some sociologist comes in in their open-toed sandals. I think they've lost it before they've even walked in, and its something to do with the culture.... From a very early stage they get this sort of professionalisation, and that's what happens. They want to be taught by real doctors..I think if a GP stands up in front of*

them and says "look, you know, I have this problem, I've got this old lady"... gives them a real concrete problem that they can hang their bits of Sociology onto, they'll accept that much better.

Even one of the teachers of Psychology felt that some of the messages he tried to put across in his lectures, in this case about changing health behaviour, would be more effective if expressed by medical doctors:

I think they need a show put across by (Dean of the Medical School) *before they actually act on anything.*

The fate of the integrated course

The rationale chapter set a complex, inter-related objective on the subject of integration. We have already looked at the problems that were thought to surround the integration of the psycho-social sciences with the mainstream curriculum. This section will look at the problems that surrounded the integration of Psychology, Sociology, and Public Health Medicine with one another.

- ***This thesis will explore the issue of integration in the medical curriculum in question. This will include looking at whether the specialties that are most likely to teach health promotion were integrated with one another.***

As we have already indicated, at the time of this research, the three groups were just coming out of what they described as an integrated phase. They had just been through several years of organising their teaching under the overall heading of *'psycho-social and Public Health Medicine'*, with each discipline giving separate lectures, but under a key term theme which ran through each of the 6 terms of the first two years.

The general opinion was that, despite many people having put in a great deal of effort, this attempt at integration had not worked. For example, in the disarmingly honest view of the one of the teachers of Public Health, who had attempted to lead the initiative, '*in retrospect I think that was ill-conceived, and badly executed, and it didn't work, if you want my frank view.*'

The consensus among all who taught it was that a large part of the problem was that the team that planned it were all new to the job, and thus '*naively idealistic*' as one of the psycho-social science teachers, who had been involved in the initiative, put it. They had taken on the teaching of no less than 30% of the total student timetable but found they could not sustain the drive, or as one of the staff from Public Health Medicine described the process, *'to be honest we couldn't find enough stuff to fill it'*.

The original conception was that the teaching would be based on small group work. However the increase in student numbers from 120 to 160, and a reported lack of support from all three departments in terms of providing people to teach, meant that teaching had to revert to the lecture format, which diminished the quality of the experience from the students' point of view. A further problem was thought to be tutor expertise. The groups were supposed to have been lead by a range of staff from different disciplines, but one of the teachers of Public Health Medicine felt that the *'multi-disciplinary tutorials'* had not worked as tutors *'didn't necessarily have the expertise without the training and the materials'*. One of those in Public Health expressed the view that his group had made the effort to teach Sociology, but that their effort had not been reciprocated:

> *When it came to randomised controlled trials they threw up their hands in horror and said, "We can't do this" and retreated.*

A psycho-social science teacher, who was one of the designers of the integrated course, reported that later staff changes meant that the initial enthusiasm and expertise at integration was not owned by the new staff coming in. She felt that the course never stabilised, nor became routinised and easy to teach.

All three groups were now of the opinion that they needed to separate their teaching more in the minds of the students. Public Health Medicine was particularly keen to be seen as distinct, and was now billing its lectures separately, and emphasising the commonality of Public Health Medicine with the clinicians rather than the psycho-social scientists. They were also keen to lose their role in running the course and encourage the other two groups to take more responsibility: as one of the teachers of Public Health Medicine put it, *'it's not my responsibility to write up what Sociology is teaching in term five'.*

Those who had observed the process from outside were very critical of it: we have already seen for example that one of the coordinators from the first two years was highly vexed about the amout of curriculum time given over to psycho-social science, and, in his view, their inability to fill it productively. Similarly a systems term coordinator felt that the psycho-social course had deteriorated: he believed that the current batch of psycho-social science teachers were not as involved or as committed as previous teachers, who had looked at more relevant topics. He felt that the psycho-social scientists who had *'clamoured for all that time'* had in practice not actually wanted to teach it. The particular staff involved had now moved on, and in his opinion the course had degenerated into what he saw as a series of tedious lectures on outdated topics, that the staff appeared to have given many times:

> *some chap turns up with a set of notes, which is probably from a lecture they he did two or three years before, which is vaguely relevant and stands up front and talks to them for three quarters of an hour and they write it all down, and we are back where we were 5 or 6 years ago.*

Summary of psycho-social issues

Primary Medical Care and Geriatric Medicine strongly supported the teaching of a *'psycho-social perspective'*, using that term explicitly, and themselves employed specialist psycho-social scientists to teach it. Apart from that, very few of the clinical elements claimed to teach a *'psycho-social perspective'*, using that term: they did teach about social and psychological issues, but under the heading *'holism'*, which will be discussed later.

A range of social and psychological issues of central relevance to health promotion were covered in the teaching of the Psychology and Sociology courses that ran through the first two years, although the total time available for the two courses was only about 48 hours across the two years.

Issues taught in Sociology included: inequality, poverty and health; lifestyle; the community; the role of the doctor; a critique of medicine; social meanings of illness; doctor-patient communication; the role of the family in health; health policy; primary care; and ways of involving the patient in health care. The coordinator of Sociology did not think it appropriate to teach about 'radical social change' as he thought such approaches had little chance of being realised.

Issues taught in Psychology included: prevention in general; risk factors; social factors; 'the limited usefulness of telling people what to do'; the prevention of smoking and smoking cessation; the prevention of cardio-vascular disease through lifestyle changes; 'the health belief model'; and the students' own health.

Staff from Public Health Medicine were generally supportive of the psycho-social sciences, particularly Sociology, but generally ambivalent about whether they themselves taught social science. They did however teach three issues in particular that this thesis has categorised as 'social', which were epidemiology, risk and healthy public policy.

Epidemiology was taught in the majority of the basic science courses, mainly by the Public Health Medicine group, and mainly in term two, the Cardio-Pulmonary System course. Many of the Public Health Medicine group seemed to see the teaching of epidemiology as their main *raison d'etre.* In the clinical years it was mentioned in relation to the two Psychiatry attachments.

Risk was taught in the basic sciences, again mostly by the Public Health Medicine group and to some extent by Psychology, and again mostly in term two. Risk was taught in a few of the clinical attachments, but very much opportunistically and in passing: only Psychiatry took epidemiology seriously enough to mention it among its written aims for its two

attachments.

Healthy Public Policy was seen by Public Health Medicine as an important issue which they were intending to teach more about: it appeared that in this group only the specialist in health promotion taught about it currently in the one lecture on health promotion. There were some lectures on health policy in general in the Sociology course, which had come about serendipitously, and could therefore presumably just as easily be removed again.

There was generally thought to be a problem with the teaching of psycho-social science. It was widely seen as not sufficiently integrated into the rest of the curriculum. All but one who commented on the subject said that the medical students did not on the whole like the teaching of psycho-social science. Several staff felt that this was partly to do with the students' anxiety about their assessment, which lead them to concentrate on learning facts, and partly to do with the transmission to students of hostile attitudes towards the psycho-social sciences, and its marginalisation, by mainstream medical teachers. Several staff conceptualised the problem as a clash of cultures or epistemologies, with psycho-social science, being perceived as interpretive, reflective and abstract, in contrast to medicine which was seen as positivist, concrete and facts based. It was felt that different teaching methods reflected this divide. Psycho-social science also tended to be seen as commonsense and thus rejected by students, and some staff, as unworthy of serious effort and consideration. Sociology seemed to suffer from the negative perceptions associated with the psycho-social sciences more than did Psychology, and to be the more disliked and marginalised. It was thought that the 'collective' approach of Sociology was harder to integrate with a medical approach than was the individualised approach of Psychology.

Psycho-social science staff themselves felt that they worked hard to teach issues of relevance to the medical students, but reported a certain degree of ambivalence about teaching them. Other staff felt that the teaching of psycho-social issues should be made still more relevant to medical problems, be subject to closer specification by the medical school as to what should be covered, be taught by staff based in the medical school rather than without, and, some felt, be taught by doctors rather than specialist staff.

A recent effort that had been made to integrate the teaching of Psychology, Sociology and Public Health Medicine together was generally thought to have failed, partly because the staff who had set it up had moved on, and partly because the team that planned the course had 'bitten off more than they could chew', resulting in more time being allocated to these subjects than there was energy and commitment to fill, which created resentment in other staff, who felt that their more mainstream teaching was unnecessarily deprived of precious time.

HOLISM

The centrality of holism, patient centredness and communication to clinical staff

We come now to three related issues, holism, patient centredness, and communication, about which medical staff, and in particular clinical staff talked of at length, with great warmth and in animated and positive terms. Their enthusiasm was particularly striking when compared with the half hearted or in comprehending reactions of many staff to questions about the issues talked of in the first findings chapter, health promotion and prevention.

What was meant by the term *'holism'*

Although critical of the psycho-social sciences, as we have already indicated, clinical staff did themselves often use a version of a psycho-social perspective but they did so very much on their own terms, using words and concepts which had a more applied and patient oriented flavour. The favoured term for such an approach was *'holism'*.

The main difference between the use of this word and the term *'psycho-social'* was that, when used in the clinical context, the word *'holism'* invariably included the patient. It was used to refer to seeing a patient's problem or the patient themselves as a whole, in the sense of taking into account a range of social, psychological or sometimes epidemiological factors which went beyond the biological when looking at the patient and their illness. It meant recognising that the patient was more than their physical symptoms, but had a mind, emotions, beliefs and a social and familial context which the doctor needed to take into account. Holism was often implicitly or explicitly defined by its obverse, a biomedical perspective, in which patients were treated as biological organisms, manifesting physical symptoms, which medicine was called on to diagnose and cure, with drugs or surgery.

In the interviews too, the two ideas of holism and patient centredness were often strongly interconnected by staff. One teacher from Primary Medical Care commented on their interrelatedness:

> *once you consider things from the patients' point of view, it is actually not possible to separate out the physical, the psychological and the social.*

When using the words *'patient centredness'*, staff tended to use them to refer to a sense of psychological empathy, of seeing things from the patient's point of view. Some staff also used the words *'patient centredness'* to refer to having respect for the patient, recognising that they had rights, and that their dignity and autonomy needed to be respected. So the term *'patient centredness'* will be looked at later, separately from holism, although it should be kept in mind that many staff connected the concepts, and some staff used the two terms

interchangeably. There will therefor inevitably be cross referencing between the sections that follow.

Use of the term '*holism*'

A word search of the interviews was carried out on the words *'holism/ holistic'* The results, grouped in clusters of specialties, are shown in table F14. It shows that the actual words were particularly likely to be used by hospital clinicians, Primary Medical Care clinicians, and psycho-social scientists, about half of whom used them, while the basic scientists and Public Health specialists did not use the words at all. So, as a concept, it was particularly linked to the clinical and psycho-social elements of the course.

Holism in the course as a whole

Table F15 summarises the state of holism in the clinical courses in the medical curriculum. It includes not only instances when the actual words '*holism/holistic'* were used, but also instances where the concept of seeing the patient as a whole was clearly being expressed in other words. It would appear that the idea of holism had widespread currency.

The coordinator of the third year claimed that the transmission of a holistic approach was one of the aims of the third year, which she summarised as:

> *about integrating basic science, the family, the effect of disease on the patient and their family and the basic clinical skills.*

Later in the interview she expressed cynicism about how widespread holism would be, and thought the students would get a '*holistic'* view in some specialties, but not in all:

> *they're not going to get the holistic view in Medicine, you know, it's "Poke that liver"... but again, so it's patchy, and I think that in Primary Care, probably in Elderly Care, Palliative Care, and they will get it possibly in Psychiatry.... I think it goes with the specialty, it goes with the territories actually. Surgery and Medicine, forget it, dream on.*

She characterised the specialities where holism might be found as lower status, '*Cinderella'* specialties, but said that Anaesthetics, which she saw as a higher status speciality, was surprisingly *'holistic'*:

> *whether its the intensive care aspect and things I don't know, but they actually get a whole lot of stuff there about breaking bad news, which you might not expect particularly.*

The coordinator of the Clinical Foundation course talked of what he termed '*a sort of holistic approach'* which he said was taught both in his course and the course as a whole:

Table F14 Use of words *'holism/ holistic'*

Group		*holism/ holistic*
3 Overall course coordinators	Number of times words used	2
	Average usage per person using them	2
	Proportion of interviewees using words	1/3 (33%)
7 Basic scientists	Number of times words used	0
	Average usage per person using them	0
	Proportion of interviewees using words	0/7 (0%)
18 Hospital based clinicians	Number of times words used	10
	Average usage per person using them	1.1
	Proportion of interviewees using words	9/18 (50%)
5 Primary Care Specialists	Number of times words used	7
	Average usage per person using them	3.5
	Proportion of interviewees using words	2/5 (40%)
3 Psychologists	Number of times words used	1
	Average usage per person using them	1
	Proportion of interviewees using words	1/3 (33%)
1 Sociologist	Number of times words used	1
	Average usage per person using them	1
	Proportion of interviewees using words	1/1 (100%)
6 Public Health Specialists	Number of times words used	0
	Average usage per person using them	0
	Proportion of interviewees using words	0/6 (0%)
Subtotals for 23 clinical staff	**Number of times words used**	**17**
	Average usage per person using them	**1.5**
	Proportion of interviewees using words	**11/23 (47%)**
Totals for all staff	**Total number of times words used**	**21**
	Total average usage per person using them	**1.5**
	Total proportion of interviewees using the words	**14/43 (33%)**

Table F15 *'Holism'* in the medical curriculum[1]

Course	In medical curriculum book	According to staff in interview
Course as a whole	Aim *'to provide knowledge and understanding of:* *-the sciences upon which medicine depends* *-human relationships in the context of the family, community and society, and the interaction between human beings and their environment'*	Coordinator of CFC thought'*holism'* now permeated the course as a whole
EPC Human Reproduction	Aim *'to appreciate the importance of the patient's social and economic background in relation to a clinical situation'*	
EPC PMC	Aim *'to illustrate the ways in which psychological, sociological and physical factors may all interact and contribute to illness'*	
Clinical attach Year 3 and 4		Implied in 'taking a history', which included psychological and social history 3rd year coordinator said the clinical course was *'holistic'* and '*about integrating basic science, the family, the effect of disease on the patient and their family and the basic clinical skills'*. But thought that in practice it likely to be *'patchy'*
CFC	Aims: *-'assessment of the presenting problems: how to work out what is really important for the patient, getting below the psychological surface* *- assessing psychological wellbeing* *- screening clinical assessment (history/examination)...includes the assessment of psychological aspects'*	Coordinator said a *'holistic'* approach was key: *'you are dealing a person in his social context, in his family context, with his past experiences, future aspirations...'*
Medicine	Methods: *'dealing with patients' relatives, social aspects of patients' illnesses and rehabilitation'*	
Surgery	Aim: '*to relate clinical disorders to the patient and his family'*	*Aim: 'they* (the students) *would be expected not just to look at the disease process but look into the patient's context in terms of where they're coming from socially, where they're going to after the operation. How are psycho-social factors interacting with their disease.*
Child Health	Aim: *'employing a holistic approach to child care which includes clinical..., family, social and psychiatric aspects'*	

Geriatric Medicine	Aim: *'gain an understanding of the holistic approach to patient care'*	Said more emphasis than 10 years ago joint appointments with social work
Psychiatry	Aims: - *'learn about the effects of these disorders on patients and their families* - *'develop a family and community perspective of* (sic) *mental health problems'*	Said specialty *'holistic by definition'* taught *'holistic'* approach to history taking
PMC	Aims (mostly about communication and relationships: 1 especially holistic): *'have an understanding of the effect of illness on the patient as a whole and on the patient's family'.*	Said holism was key approach for specialty and for course 2 staff said they were highly sympathetic to psycho-social sciences
Palliative Care	Aim: *'understand the range of psycho-social issues for patients and their families'*	Key approach for specialty and for course concentrated on emotional and social sides of cancer Taught *'story'* based approach to history taking
Neurology		Talked in detail about the process of *'taking a social history'*
Dermatology		Said they taught social impact of skin disease
GU		Said holism was key approach for speciality and for course Said they taught wider social implications of GU medicine
Year 5		
O&G	Aims include reference to *'social and psychological factors in human reproduction'.*	
Psychiatry		Said specialty *'holistic by definition'* Said they taught *'holistic'* approach to history taking Said students gain awareness of psychological approaches to treatment in theory, but not in practice
Total (from 38 elements)[2]	12	12

Notes

1. This table only notes positive instances. If a column is blank, or a course is not listed, it can be assumed that the entry would have been negative.
2. *'38 elements'* refers to all the categories used for this particular analysis, which were the 31 courses, the course as a whole, first and second years, the third and fourth year, the fifth year, and Public Health Medicine, Psychology and Sociology.

I think one of the messages we try to convey in the course is that you are dealing with a patient, and you are not dealing with a disease entity, but you are dealing a person in his social context, in his family context, with his past experiences, future aspirations, that sort of thing.

He felt this holistic approach had greatly developed within medicine since he was a student:

when I went to Medical School we were taught how to recognise a given disease, how to make differential diagnosis, how to treat that disease.

He went so far as to put the development of the holistic approach forward as, *'one of the greatest achievements of modern clinical teaching'.*

Holism was taught in all the clinical courses in so far as it was implied by the concept of 'taking of a history'. This 'history' was generally taken to include social and psychological information about the patient as well as a information about the physical disease from which the patient was suffering. Taking a history was taught in the Clinical Foundation Course and the skills learned there reinforced across the subsequent clinical attachments. As we can see from table F15, the list of 7 *'skills'* this course aimed to teach did indeed include three connected with assessing the patient's psychological state.

The coordinator of the Neurology attachment could be seen as speaking for many of the attachments when he described the routine process of taking a social history, about which he said, *'I would imagine* (it) *...probably happens in every clinical discussion'*:

we go through the social history at the same time as the case is taken. "What do they do at home? How is the family coping with the breadwinner not working?" If you want to discharge this patient, who is at home; how is he likely to cope?" And so on. We deal with this as part of the history, part of the assessment really....There isn't something designated specifically for it, but they do it as they go along really. I would imagine it probably happens in every clinical discussion .....it is always discussed in ward rounds.

So, to the extent that they all taught or reinforced the skills of taking a history, all the clinical attachments could be said to have taught about holism.

Holism in Primary Medical Care

Staff in Primary Medical Care were unusual among the clinicians in seeing a clear link between the patient focused concept of holism and the psycho-social sciences, thus providing holism with a theoretical base. One of the teachers expressed this linkage particularly clearly, and contrasted it with the 'scientific' view of mainstream medicine:

in Primary Care, being holistic, we are very interested in the social science view of the world of culture, and not just the scientific, and that really is quite

a threat.. to those who see science as a religion.

The group were particularly sympathetic towards and interested in the psycho-social sciences themselves. The Chair of the group said that Primary Medical Care was essentially concerned with integrating a range of approaches, including what she and others in her group tended to term a *'social science perspective'*:

> *we have something important to say about the individual and linking in social science and the biological sides. We see ourselves as an integrative focus.*

The group had recently appointed an anthropologist who, the Chair of the group said, had been *'instrumental in ...linking in the idea of the individual in their social context'* and was an appointment which she saw as *'highly symbolic'* of the integrative values represented by Primary Medical Care.

Another member of the Primary Medical Care group staff talked of a *'major tension'* in the medical curriculum between what he called the *'interpretive view of social science and the factual view of science.'* To him Primary Medical Care was about teaching students to have a broader vision than the narrow one of traditional science:

> *embracing other philosophies and cultures as well as the scientific, purely narrow scientific culture. It's teaching them* (i.e. the medical students) *that good science is much broader than these narrow views offered.*

Primary Medical Care had apparently built the idea of holism into their everyday, routine teaching as a central value and recurrent theme, and examples of it ran through all their accounts of how and what they taught. For example, the Chair of the group described what she saw as a typical seminar, in which a group of students were presented with the case of a child with earache: she said that in her judgement, *'somebody's best thinking will be "Well what about the social situation?"* Similarly another said that, when offering feedback to the students who had been playing the role of 'doctor' in the role plays of the OSCE:

> *I find that is the most helpful thing....., when I am giving feedback as the observer, to say to them, "and what other things about this patient could you have asked?"*

However, all 5 staff interviewed from Primary Medical Care remarked that such holistic ideas did not come easily to students. As one put it:

> *there are some students who just home straight in on the clinical stuff, and never realise that this is a person who may have a life out there, and it is actually important to find out where do they work, and whether there are any confounding factors, and so on.*

To revisit what is becoming a common thread, again some students apparently tended to dismiss holism as obvious, easy, common sense. One of the teachers of Primary Medical Care saw the early coverage of what he called the *'holistic side'* of medicine in the curriculum as a mixed blessing:

> *it is making them more sympathetic and also making them slightly more antagonistic...the fact that they've had it early in the curriculum, they will then say "What are you telling us this for? We've already done this."*

To compensate for these simplistic assumptions, some staff in Primary Medical Care were reportedly at pains to demonstrate to the students the complexity of holism. As one teacher said:

> *you have got to deal with quite a lot of stuff in the student, to actually get to help them to understand that what it means to be holistic is actually multi layered and multi dimensional, and there are lots of different ways of understanding and interpreting.*

He felt that generally students were '*sympathetic*' to holism, but that this was a difficult attitude to nurture, given the '*ticking a tick box approach*' the rest of the curriculum encouraged.

Holism in Geriatrics

Like Primary Medical Care, this clinical group appeared to be unusually keen on the psycho-social sciences themselves. The coordinator said there was more emphasis on psycho-social issues in his speciality than there was 10 years ago, as evidenced by joint appointments between his group and social work. From his account of the topics taught by the two jointly appointed staff, it appeared that they touched on both psychological and social issues:

> (name)*'s whole work really is about self esteem, psychological well being, and* (name) *works on relationships and how things like family determine well being in old age, ...so there are sessions on the Psychology of ageing, long term care, and* (name) *does the session on separation and attachment.*

Agreeing implicitly with his colleagues in Primary Medical Care, he went on to say that such teaching by psycho-social scientists was not popular with the students, who often dismissed it as obvious common sense: this was an attitude with which he clearly had little sympathy and to which he made no concessions:

> *I think both sides of the equation* (i.e. the psycho-social scientists and the students) *find it pretty hard going, because actually, medical students, that is an area which they often do rate badly. Well tough. I mean they say "It's*

obvious" and "We don't really see the point of knowing about that kind of thing". Well, I think that is a kind of area where I am afraid they are just going to have to put up with it.

Although unusually willing to use the term *'psycho-social'*, the attachment also used the word *'holistic'*: as table F15 shows, the aims of the Geriatric Medicine attachment included intending that students would *'gain an understanding of the holistic approach to patient care'*. The interview with the coordinator confirmed that this specialty was particularly supportive of a holistic approach.

Holism in Psychiatry

Both the coordinators of Psychiatry in the third and the fifth years spoke with one voice on this issue. Both said that the discipline was *'holistic'*, as one said, *'by definition'*. Both claimed that they stressed to students that the *'standard medical history'* they were taught to take had to be *'much more detailed than those of a 'medical or surgical attachment'*. As the fifth year coordinator said:

just the fact of learning to take a Psychiatric history does to some extent give you a holistic view, because you have to ask all about the patients' development, background, social circumstances, and so on.

The third year coordinator said that right *'right from the word go'* students were taught, when taking a history, to gather information from a range of sources, which included *'the patient and ... family members, Primary Care, other members of your team'*. He concluded that such teaching added up to a holistic approach:

So I am now fairly confident that they get the message that you need to consider holistic, whole patient care, in our attachment anyway.

The coordinator of the fifth year Psychiatry attachment was rather less optimistic. He wondered whether students generalised to other specialities from their experience in the Psychiatry attachment, *'very often they just see it as a very specific task that has got to be done in Psychiatry.'* He also wondered whether the holistic approach was carried over to the treatments students experienced in practice.

It appeared from the course documentation that the Psychiatry attachment made use of a range of therapies, which themselves represented a holistic approach to patient treatment and care. The medical curriculum booklet said that learning about a range of *'drug, psychological and social therapies'* was one of the aims of the fifth year attachment, and this coordinator confirmed that students were taught about social and psychological treatments as well as pharmacological treatments:

(students are taught) *to have a thorough knowledge of psychological and social aspects of treatment... to be aware that there is a whole family of psychological treatments of different kinds for different purposes.*

He also said that students would learn about some conditions to which psychological treatments applied:

they would know that for eating disorders, and for substance misuse, and anxiety disorders, that really psychological treatment is the main treatment.

However, it appeared that such a holistic approach to treatment was theoretical only. The coordinator said that, on the whole, students' learning about psychological or social treatments would be at the level of *'awareness'* only, and that in practice students would not see very much psychological treatment, and would not learn any psychological skills, unless they were particularly keen to follow them up themselves. He felt that students would go away with the impression that drug treatment was the only realistic option in Psychiatry in most circumstances:

(students would) *get a pragmatic view that drug treatment often forms the mainstay of most care, because it is available, and psychological treatment is in very short supply, rather specialised, hard to come by, with long waiting lists.*

Holism in Palliative Care

Like staff from Primary Medical Care, the coordinator of Palliative Care also appeared to feel that this attachment provided a contrast to mainstream medicine. In this case, the contrast was said to be the emphasis on affect. The attachment was said to be predominantly concerned with the emotional side of cancer, from the patient's point of view, and on students' emotional reactions to the demands of the discipline. The coordinator said the attachment looked at '*pain'* and '*suffering*' as well as '*symptoms*', and that its practice relied a great deal on *'intuition*', in contrast to what he characterised as a *'scientific'*, *'practical'* and *'medical'* approach in which, '*real doctors do macho things'*:

ours tends not to be the scientific sort of approach... its how you actually deal with it, what the issues are and a real person who hurts, what's going on. Its not very practical, but it's actually opening out what pain and suffering are, because the two are terribly interlinked.

He said he told students that it is permissible to cry when moved by a patient, which he said was *'not desperately medical is it? But for a Consultant to say that is quite useful.'* Given his unusual stance, he pondered on whether he was *'a proper doctor anymore'*, but reported with pleasure that one of his patients had told him that if this was so, then, *'don't ever be a proper doctor'*.

This coordinator felt the students were not all receptive to this alternative approach, *'a lot of them* (the students) *are very inured to it, because of the medical model'*, but ultimately he was content if the students simply had an experience of facing the emotional side of cancer, and went away realising that it could be coped with, *'they have seen that you don't fall apart.'* He may have underestimated the extent to which the students appreciated his approach, as, according to the coordinator of the third year, they came back from the attachment *'all fired up: they love it'.*

However, this coordinator was also adamant that doctors should stick to what they know well, and not stray into claiming to be psychological or spiritual gurus:

> (to say that) *the doctor can actually provide this spiritual care or this psychological care ....it's rubbish really, it's rubbish...So I think it's actually about being honest with ourselves, to look at what we do well and not do the things we do badly.*

Holism in the other attachments

Some other attachments also claimed to take a holistic approach.

The aims of the third year Child Health attachment written in the medical curriculum book included teaching students to employ *'a holistic approach to child care, which includes clinical, family, social and psychiatric aspects'.* In interview, the coordinator confirmed that the fundamental aims of the attachment were *'holistic'*, using that term: he said they were aiming to teach students:

> *to recognise some common abnormalities of health and development and to put them into the context of that holistic approach to child care, so we include social, community, ethical Psychiatry, Public Health issues.*

The coordinator of the Genito-Urinary attachments reported similarly holistic goals:

> *The implications of the problem to the patient, their immediate family, and to the community in general, that is what we are about. To try and stop them* (i.e. the students) *thinking of it just as being diagnosis, treatment, cure....It is about the opportunity to affect the health of the community, the future of the individual, educational opportunities.*

Interestingly he saw the taking of a holistic view as an essential foundation for prevention, and both as integral to the central purpose of GU medicine:

> *our problem is, with our course, what is unique, is that it is so easy to diagnose and treat the problems we deal with, or just to treat them, without taking that bigger step. And if you don't take that bigger step, the patient comes back with the problem, gets the complications and their partners and*

the community suffers....Our job, I feel, is to emphasise that element,... that is so important.

The coordinator of Early Patient Contact, Human Reproduction was adamant that taking a psycho-social perspective was basic to clinical practice, although, like the students, he seemed to see it as common sense:

I think any doctor I think worth their salt, teaching the thing, will pick up on those dimensions of illness and reinforce the points correctly....because it is inevitably your experience, you have to look after a person, that person comes from a context, and is fascinating.

The course outline for the Dermatology attachment said that it aimed to teach students about '*the social impact of skin disease*'. The coordinator thought that all specialties would probably claim to be holistic, but that their attachment was especially concerned with teaching about social and psychological issues, given the subjective nature skin disease:

Everyone probably says this, but I think that we try and see patients more as a whole, and treat the symptoms rather than the disease, more than other specialities. Because skin disease is such an individualistic thing, and given the same amount of disease people react completely differently to it, and have different demands, different requirements. And unless those are seen in the wider context, one can't treat people properly, and that's something we do try get across in the outpatient based teaching.

He was not sure however that students always appreciated the importance of this holistic view, and said that they seemed to prefer a disease centred approach:

the students seem to perceive that the main requirements are to simply gather information and understanding of the disease, rather than the wider aspects that determine the treatment, really.

As we have seen, the coordinator of the third year thought that holism would tend to be taught by the lower status *'Cinderella'* specialties. So far, many of the specialties named as being particularly interested in holism, Primary Medical Care, Geriatrics, Psychiatry, and Palliative Care, were those that the methodology chapter argued should be categorised as lower status, although Child Health was both very interested in holism and categorised in the methodology chapter as higher status. Furthermore, Orthopaedics and Surgery, which the coordinator of the third year saw as higher status (Surgery was also thus classified in the methodology chapter), also apparently concerned themselves with some aspects of holism: the coordinators of both attachments said that they encouraged students to look at the patient's social context.

For example, the coordinator of the Orthopaedics, said that students would be taught a great

deal about the social impact of physical disability on the life of the patient:

> *We emphasise that when we discuss with them the sort of questions you would ask with what you can do in daily living. "Can you go upstairs normally? Can you get on and off the toilet?", and all this stuff. ..social aspects ..loom quite large in Orthopaedics, the social consequences of not being ambulant, of not being able to work if your hand function is poor. Yes, we discuss that considerably, at some length.*

When asked what the goals of the attachments were, the coordinator of the third and fifth year Surgical attachments talked warmly of the holistic approach which he saw as central aims for the curriculum as a whole, including Surgery:

> *I think that certainly this School has always had a holistic approach to patient management, and most of us are comfortable with that. They* (the students) *would be expected not just to look at the disease process but look into the patient's context, in terms of where they're coming from socially, where they're going to after the operation. How are psycho-social factors interacting with their disease?*

He felt that in the fifth year the students would spend even more time on understanding social issues, due to the short time that patients now spent in hospital:

> *We have patients with major sectional surgery who are home in five days, so this raises all sorts of other issues for the General Practitioner in terms of pain control and this sort of thing, and clearly the house that the patient goes back to. They've* (i.e. the students) *got to be able to understand whether it's suitable or not for such a patient.. .*

He said that students spent *'far more time'* on a holistic approach in the fifth year than in the third year Surgical attachment, and that having the Surgical attachment next to that of Primary Medical Care helped the students to *'follow up patients who have had surgical treatment so they can see the problems of them being managed post-operatively in the community'.*

However, perhaps partly justifying the cynicism of the overall coordinator of the third year about how common the treatment of holistic issues in some of the higher status attachments actually was, he went on to qualify these statements, by pointing out that the short time they had to teach the students meant that time to teach such holistic approaches was limited:

> *if we spent all our time dealing with the patient with the disease in the community then we wouldn't probably have enough time to get through what they absolutely need to get.*

It is perhaps telling that he did not include holism in his categorisation of what the students,

'absolutely need to get'.

The coordinator of the other higher status attachment, Medicine, did not mention holism specifically, although as we shall see, he talked about the related concept of patient centredness.

Summary of holism

Holism was mentioned in connection with the course as a whole, and 15 of the 21 clinical courses. The actual terms *'holism'* and/or *'holistic'* were used by nearly half of all clinicians interviewed. It was thought by several staff to permeate all the clinical elements, and be part of the skills of taking a history, which were taught and practised constantly in all attachments, and which routinely included social and psychological issues. Holism appeared to be particularly central in the lower status attachments of Primary Medical Care, Geriatric Medicine, Psychiatry, Palliative Care, and in Genito-Urinary Medicine and Dermatology. However, the coordinator of a higher status specialty, Child Health, said his specialty particularly emphasised holism, while those of two other higher status specialities, Orthopaedics and Surgery, also claimed that they emphasised holism in the particular sense of taking the social context of the patient into account, although it did not appear to be as central, in Surgery at least, as it was in the other specialities named. Several staff remarked that students found taking a holistic perspective difficult, and tended to prefer a concentration on learning facts about disease. There was some reported tendency for students, and some apparent tendency for staff, to see holism as obvious, simple, common sense, and only Primary Medical Care and Geriatric Medicine appeared to attempt to spend much time reinforcing the psycho-social science base of the holistic approach.

PATIENT CENTREDNESS

- ***This thesis will examine the extent and nature of teaching about patient centredness in the medical curriculum , and staff attitudes towards patient centredness.***

What was meant by the term *'patient centredness'*

The previous section looked at holism, which was defined as going beyond the biological, and taking into account of a range of factors, social, psychological or epidemiological when dealing with patients. The term *'patient centredness'* tended to be used to refer specifically to psychological aspects of patients, and of the doctor-patient encounter, although its use often overlapped with that of *'holism'*.

'Patient centredness' appeared sometimes to be being used by staff to refer to two distinct but closely related issues. The first was being empathic with patients, as one of the teachers from Primary Medical Care put it, '*patient-centred medicine* (is when) *you look at the things from the patient's point of view rather than the doctors'*. The second use of the word was in the sense of respect for the patient, in other words recognising their rights, dignity and autonomy in the medical encounter.

Patient centredness as a key attitude

We saw earlier, in the analysis of the answers to the question '*what kind of attitude do you hope the students will learn on your course?'*, analysed in table F2, that attitudes to do with patient centredness were those most frequently mentioned. Table F16 looks more closely at the responses and breaks them down course by course. It shows that the attitude of patient centredness itself received 23 mentions in all, with that specific term being used by the coordinators of the whole course, the first two years and the third year, and 19 of the 24 clinical courses. The attachments where the coordinators mentioned teaching this attitude included the third and fifth year attachments in Surgery and Medicine, the traditionally higher status specialties. So the importance of patient centredness could be said to have been almost universally recognised in the clinical attachments.

Patient centredness in the course as a whole

Table F17 summarises the state of patient centredness in the course as a whole. It suggests that, like holism, the issue had a widespread currency, particularly in the clinical elements of the course, and was especially likely to be discussed in interviews, being mentioned, and often commented on at length, by no less than 27 of the 38 relevant respondents.

The overall coordinator of the medical curriculum felt that patient centredness was so entrenched in the curriculum it had almost become a cliche:

> *you've probably heard, ad nauseam, about how Southampton students have always been encouraged, and sometimes assumed to be, suitably respectful, to have a general attitude which attempts to respond to patients' need. So one is always trying to encourage that.*

Patient centredness in the basic sciences

Table F17 shows that, according to the entries in the medical curriculum book, the Foundation term and term four, the Neurology Systems course, aimed to teach patient centredness, although it was not an issue on which their coordinators commented in interview. According to the course outline, the Sociology course taught a lecture called '*Consumers or patients? Involving the patient in the NHS'* in term 5, the Endocrinology, Human Reproduction, and Nephrology systems course. There was only one other mention of patient centredness in the basic sciences: the coordinator of term three, the Locomotor

Table F16 Responses about patient centredness when asked '*what kind of attitudes do you hope the students will learn on your course?*'

	Patient centred	Positive attitudes to patients
Whole course	√	
Years 1 & 2	√	
EPC PMC	√	
EPC HR	√	
Year 3 as whole	√	
Child Health	√	
Primary Care	√	
Geriatrics	√	√
Medicine	√	
O and G	√	
Palliative	√	√
Psychiatry	√	√
Surgery	√	
Dermatology	√	
GU	√	
Ortho	√	√
Child Health	√	
PMC	√	
Medicine	√	
O&G	√	
Psychiatry	√	
Surgery	√	
Total for 8 basic sci.[1]	**1**	**0**
Total for 24 clinical[2]	**20**	**4**
Total for all 34 elements[3]	**23**	**4**

Notes

1 Includes interviews with coordinators of years 1 and 2, Foundation term, 5 systems courses, and SBOM, 8 potential entries cells in all.

2. Includes interviews with coordinators of 2 Early Patient Contact courses, year 3 as a whole, the Clinical Foundation course, and the 20 clinical attachments, 24 potential entries in all.

3. Includes all under 1. and 2. plus the course as a whole, and the study in depth, 34 potential entries in all.

Table F17 ***'Patient centredness'*** **in the medical curriculum**[1]

Course	In medical curriculum book[2]	According to staff coordinator in interview (mostly in response to '*what kind of attitudes do you hope students will learn?*')
Course as a whole	Aims - *'a concern for the interests and dignity of patients'* - *'the capacity to work constructively and courteously with others'*	Said 'patient centredness' was a key aim for the course as a whole Said course tried to teach *'a suitably respectful..attitude which attempts to respond to patients' needs'*
Basic sciences/ Years 1 & 2		Said 'patient centredness' was a key attitude the first two years were trying to teach
Foundation term	Aim *'to appreciate the effect of illness on patients and their families'*	
Term 3 Locomotor		Gave an example of '*patient centred'* role modelling by clinical lecturer
Term 4 Nervous	Aim '*to illustrate the problems of neurological disease from the patient's perspective'*	
Term 5 Endocrin., Human Repro and Nephro.	Sociology lecture: *'Consumers or patients? involving the patient in the NHS'*	
EPC PMC	Aim *'to enable students to recognise some of the effects of illness on people and their 'families'.*	Said *'the listening doctor..an understanding of what empathy involves'.*
EPC HR	Aims - *'to learn from the patient about her concerns..and her immediate plans'* - *'to learn of the problems facing the mother and the newborn'*	Talked of the need to recognise patients' expertise and *'don't patronise'*
Psychology		All 3 interviewed saw teaching about the patient's perspective as a key goal for this 'thread'
Sociology		Said an aim of the 'thread' was to teach students to understand patients' cultural beliefs and perspectives
Clinical attach Year 3 and 4	Aim *'to appreciate the effects of disease on the patient and their family'*	Said key aim of the clinical years was to teach students to integrate the patient, the family, clinical skills and basic science
Clinical Foundation Course	Aim, '*assessment of presenting problems- how to work out what is really important for the patient'*	

Medicine		Said aim was to teach students to explore *'the things that the patient would be concerned about'*
Surgery	Aim *'to relate clinical disorders to the patient and his family'*.	Key attitude taught was understanding the patient in their social context
Child Health		Said the key attitudes they taught were *'to feel comfortable with children.. understand what children need and want....to empathise with parents and understand how parents see and think'*
O&G		Said *'patient centredness..that is a culture in our department... we're actually dealing with patients' perceptions of illness as opposed to disease'*
PMC	5 aims: *'students should be able to....* *- establish an effective relationship with a patient* *-listen attentively to patients..* *-find out why the patient came that day* *- explore the patient's ideas about their problem and its management* *-have an understanding of the effect of illness on the patient as a whole*	All 5 staff interviewed talked of teaching 'patient centredness' as key aim for the specialty.
Palliative Care	Aim *'show how a diagnosis of cancer affects patients and families'*.	Said the key attitude was *'to treat them* (patients) *as human beings and ..realise that they have all got a story really; they are all fascinating'* Talked generally of teaching the skills involved in being 'patient centred'
Psychiatry	Aim *'learn about the effects of these disorders on patients and their families'*	Said *'we hope that they find patients with mental health problems as interesting and as challenging as people with physical health problems'*
Geriatrics		Said that they wanted students to realise that the elderly *'have had rich and varied lives, because they have had long lives, so that they are actually interesting people to talk to'*
Project		If the student chooses it
Dermatology		Said they tried to teach students *'respect for their* (patients') *privacy, reducing pain when examining them and trying to deal with the issues that the patients bring up rather than the ones that we feel that they ought to be presenting to us'*
Eyes		Said they tried to teach students *'being courteous to the patient'* and *'not just taking patients' feelings for granted*
GU		Said they tried to teach students *'being non-judgmental'* and *'understanding the weaknesses of human nature'*

Orthopaedics		Said they tried to teach students to: -to listen to the patients and use what they said as a basis for diagnosis and treatment - *'treat patients with respect..talking to patients, and treating them properly'* particularly by being clean and appropriately dressed
ENT		Said they tried to teach students *'respect for patients'* and not *'to take their feelings for granted'.*
Year 5		
Child Health		As for 3rd year Child Health attachment
PMC	Aim *'to understand the patient centred philosophy of general practice..'*	Talked of teaching 'patient centredness' as key aim for the specialty
Medicine		As for 3rd year Medicine attachment
O&G		As for 3rd year O&G attachment
Psychiatry	Aim *'have some appreciation of prevailing attitudes to mental illness including stigma..'*	Said they tried to teach students *'becoming comfortable with the notion of mental illness; de-mythologising a lot of the stigma'*
Surgery		As for 3rd year Surgery attachment
Total (from 38 potential elements)[3]	**13**	**28**

Notes

1. This table only notes positive instances. If a column is blank, or a course is not listed, it can be assumed that the entry would have been negative.
2. As the 'threads' of Public Health Medicine, Psychology and Sociology did not have an entry in the medical curriculum book, their course handbooks have been used instead.
3. *'38 potential elements'* refers to all the categories used for this particular analysis, which were the 31 courses, the course as a whole, 1st and 2nd years, the 3rd and 4th year, the 5th year, and the 'threads' of Public Health Medicine, Psychology and Sociology.

systems course, said that the clinicians who taught on the courses sometimes brought with them a flavour of patient centredness: to illustrate this she told a story of a surgeon who particularly role modelled patient centredness, in the sense of respect, to a group of students in a lecture. It was an example which the students apparently valued:

> *That* (i.e. patient centredness) *is emphasised, or has been emphasised in the past, when orthopaedics brought the patients in to the students. OK it was only a couple of sessions, but eminent surgeons helping the old lady put her stockings on after examining her legs, got across without it being expressed verbally that this was a person and that the surgeons were so sweet and helpful....I certainly remember one surgeon getting a round of applause for helping the old lady.*

Patient centredness in the clinical attachments

Patient centredness was seen by respondents as absolutely central to the majority of the clinical attachments, where it had an even more widespread currency than holism, being owned more evenly, and more unequivocally by higher status as well as lower status specialties. Most clinical staff had a great deal to say about it, and talked about it for longer than any other single issue.

The coordinator of the third year as a whole thought the central aim of the year was to help students understand *'the effect of disease on the patient and their family'*, an aim which was phrased almost verbatim in the medical curriculum book.

Patient centredness, like holism could be seen as related to the routine business of taking a history, which as we have seen was nominated as an aim for all the clinical courses, as taking a history often included an assessment of psychological state. This link was explicitly made for some courses: for example, in the entry under *'aims'* in the medical curriculum booklet, the Clinical Foundation Course suggested that in the *'assessment of presenting problem'* as they called it, should include psychological empathy, looking at '*how to work out what is really important for the patient*'.

Patient centredness in Primary Medical Care

Patient Centredness was central to the third year Primary Medical Care attachment where, as table F17 indicates, no less than 8 of the 10 competences could be seen as essentially concerned with it. They included, for example *'explore the patient's ideas about their problem and its management'*. All 5 of the staff interviewed in Primary Medical Care agreed that their central value was what the Chair of the group described as '*the whole patient-centred business of respecting the individual in their social context and listening well to what they have to say';* another person said it was *'absolutely key'*. Yet another described it *'the core of the way we teach'* and indicated that there was '*increasing scientific support for that approach*':

on the literature both about communication and about patient-centred approach, and how it actually really does improve outcome. And it is nice to be able to add that to our previous article of faith.

'Patient centredness', using those very words, was also stated as a specific written aim for the fifth year Primary Medical Care attachment, which included helping students:

understand the patient centred philosophy of general practice and how this is complementary to the task of medicine as a whole.

Two members of staff felt that Primary Medical Care formed a contrast to other disciplines in its emphasis on patient centredness. One simply felt that they were *'trying to be a more patient-centred approach than perhaps some other disciplines'*. Another articulated what he called his own '*core value*' as being *'people are the most valuable, and you shouldn't in any way objectify people'*. He saw in traditional medicine, '*such a ready tendency to objectify human beings in medicine...to focus on diseases rather than on people'*.

It appeared that patient centredness in Primary Medical Care went deep, as all 5 staff talked at length about the philosophy behind it, with three of them mentioning academic texts they had recently read on the subject. One in particular articulated at some length the concept of respect for patients, which he felt was manifested through understanding patients' health beliefs, exchanging the different types of knowledge each party had:

they've got their own health beliefs; they've got their own rationalisations... Trying to find out what things mean for them first of all, and trying to fit in with that to help them to get to where they want to go. Basically, as a professional person, you have a type of knowledge, they have a type of knowledge, but there needs to be some non threatening exchange of that knowledge from both sides, some sort of optimum exchange of knowledge, to allow that person to make a decision about their health or whatever.

He also felt that patient centredness was about understanding patients' priorities and fears:

Professionals will complain about calling the doctor out at night for something trivial, but the patient centred doctored would say "But it isn't actually trivial to them, or they wouldn't be contacting you."

He felt that patient centredness was now so well known in Primary Medical Care that it had become a cliche, and the time had come to explore it in more depth and think further about its meaning:

Well patient centredness is absolutely key, but like so many things we use cliches, you know 'education' or 'empowerment', or 'patient centred', and the thing is, what does that cliche mean?

Patient centredness, in the sense of psychological empathy, was clearly built into Primary Medical Care teaching in a routine and fundamental way. Several staff described at length the techniques they used to teach patient centredness. One talked of injecting patient centred questions into discussions with students about patients:

> *and if students come up with a one-sided view of this patient in terms of disease..... my approach to that always would be to again ask questions, "How does the patient feel about this?", "What seems to be important to the patient?"*

The Chair of the group talked about the way in which the attachment actively involved real patients in the teaching, encouraging the students to listen to what the patients had to tell them, *'I think we teach them that the patient can help you to help them get better, when we are doing it well'*. She gave a vivid example of teaching students to carry out a cervical smear with the patient giving feedback:

> *when I have been teaching a young man how to do a cervical smear, and I am saying to him "keep asking her whether it is hurting" and the patient is really getting into that and "(scream).. no, no, a little to the right.." and those people know how to take cervical smears at the end of it, and the patient has been willing to help them.*

She contrasted this patient centred approach with the approach to teaching the taking of a cervical smear using unconscious patients:

> *not doing it on an anaesthetised female in the theatre, where you learn how to hurt people, because they are all floppy and relaxed and it is not like the real thing, and they don't screech when you catch their hairs.*

Patient centredness, in the sense of empathy, perhaps reached its apotheosis in Primary Medical Care in the OSCE, which, as has been mentioned already, was a student assessment involving consultations with simulated patients, on which students were given feedback. In fact two of the 7 seminars were OSCEs, the first involving just the students and staff taking it in turn to act as 'patients', 'doctors' and assessors. The second OSCE kept the students in the 'doctor' role and hired professional actors to be 'patients', so keen were the group on verisimilitude. In the 10 item scale used for grading the consultations, 9 of the items were concerned with patient centredness (for example, item 1 was *'establishing a relationship with the patient and demonstrating respect for the patient as a person'*, while item 10 was *'involving the patient in decision making and care'*). After the consultation, there was feedback, in which the student who had played the 'doctor' reflected on what they thought they did well and what they did badly, followed by the 'patient', still in role, who reported to them their experience of the consultation.

On the whole Primary Medical Care staff felt that such teaching about patient centredness went down very well with students, and that its credibility was high. One felt however that the students '*get almost bored with us saying "what is the patient's view of the situation?"*', while another wondered whether some students were simply giving them what they knew they wanted to hear, and that the cynical *'streetwise'* student view of Primary Medical Care might be, '"*oh they're all touchy feely and luvy dovy, and all you have to do is look as though you are interested.*"'

Patient centredness in the other clinical attachments

The coordinator of the third year Obstetrics and Gynaecology attachment felt that patient centredness formed '*the culture, believe it or not, in our department*' and was a *'key issue in our speciality'*. He pointed out that, in Obstetrics and Gynaecology, the patient's subjective assessment of the problem was at least as important as the objective status of any physical problem:

> *a lot of Obstetrics and Gynaecology is actually dealing with non-lethal disease, where we're actually dealing with patients' perceptions of illness as opposed to disease. And that's something we do go into quite a lot, even in talking about something apparently objective, like menstrual disturbance. When you get down to it, you find that half of your patients are presenting not with objectively increased menstrual loss, and their whole lifestyle is coming into play, or psychological factors come into play, and need to be considered.*

He felt that teaching what he called *'this patient centred attitude'* was a central goal for his speciality, and one that students appreciated was important:

> *this whole attitude...is something that we do highlight at every opportunity. I think students come to appreciate that.*

The coordinator of the Geriatric medicine attachment thought that his specialty was essentially concerned with teaching sensitivity to the patient's needs. He too made the point that the doctor's priorities have to recognise the patient's subjective impressions as well as the objective facts of physical disease. He went so far as to assert that the physical problems with which an elderly patient presents may form the least of the issues on which the doctor should focus, and that the doctor's role might sometimes involve deliberately <u>not</u> finding out what was physically the matter with the patient:

> *I think, particularly for the age group I am dealing with, you have to be guided by whatever their own perceptions or beliefs are. So in general, within reason, if the patient's happy I'm happy. So there are a lot of things where I don't pursue things... say I don't know the diagnoses, and I might not do any tests to try and find it out, because if it doesn't bother the patient what is wrong with them, it doesn't necessarily bother me. We might end up saying "No, I don't think it serious" and I leave at that. So that would be a major*

thrust at what I am trying to get..... and that would be very patient orientated.

Patient centredness also appeared to be particularly central to the third year Child Health attachment. It appeared that teaching in this attachment went well beyond a rhetorical urging to students to be patient centred, to teaching students positive and practical strategies for empathising with both children and parents, and furthermore how to use this empathic understanding to help their diagnostic procedures. The coordinator said:

> *We have to spend quite a lot of time just getting them to feel comfortable with children, so just to feel that they can communicate with children whatever their age, and not look upon them as being a sort of dog or cat with no communication tool... and they can get down on their knees, and they can understand what children need and want, and how they can incorporate those desires into an approach to the child, in order to get the information that they need. They should be able to empathise with parents, and understand how parents see and think, and not just take what the parents say literally. They can interpret information that comes from parents as being third party information, and ask the right questions to be able to dissect out what it really means.*

We have seen that the coordinator of the Palliative Care attachment emphasised the importance of taking the patient's emotions into account. Unsurprisingly, he also saw patient centredness as one of the central value and concerns of Palliative Care, and said that a central attitude they wanted to teach students was to value patients as fascinating individuals:

> (we want the students to) *treat them* (i.e. patients) *as human beings really, and just realise that they have all got a story really. They are all fascinating, that's the awful truth, they are all fascinating*

This coordinator said that the students reported to him that this specialty was unusual in teaching them that there were relatives as well as patients to consider:

> *they comment frequently here that the thing that really shatters them is the fact that there are relatives, which they don't really see elsewhere.*

As with Child Health, the coordinator of Palliative Care indicated that this attachment attempted to teach students some of the basic skills involved in realising patient centredness in practice:

> (the students) *go in groups of three to see a patient themselves and do all the asking of the questions, and that's vary variable. I mean, sometimes a patient's depressed, sometimes they are denying, sometimes they are very open, sometimes they can't stop talking, sometimes they cry, and then we talk about how they found that, and how they actually how they felt about it.*

Similarly they encouraged students to use their own emotional reactions to patients as a guide to the patient's inner state, using concepts which appeared to draw on psycho-therapy:

> *some* (patients) *will upset them* (students) *and annoy them, and it's not wrong to be upset or annoyed. So, to trust their own emotions, and to realise that often their own emotions, when they get angry with a patient, are diagnostic, that if you are angry with a patient, you are talking to an angry patient.*

When asked about what attitudes his course was trying to transmit, the coordinator of the Dermatology attachment also mentioned patient centredness, saying that they aimed to teach students:

> *respect for their* (i.e. patients') *privacy, reducing pain when examining them, and trying to deal with the issues that the patients bring up, rather than the ones that we feel that they ought to be presenting to us.*

He said that the attachment also attempted to teach students that the psychological and social impact of skin disease on the patient was often of greater importance in determining treatment than the objective severity of the disease:

> *we certainly try and put that across to the students that they mustn't focus on simply making a diagnosis and prescribing treatment, but they must really try and gain some assessment of how the disease is, to what degree the disease is affecting aspects of the person's life....It's the psychological factors which are the main determinant of the treatment that a patient would benefit from.*

He made a similar comment to the one he made in relation to teaching a holistic approach, indicating that he was unsure how successful they were at persuading students to see the problem from the patient's point of view, '*so that's something we do try and get across, although quite how successful we are is always another matter.*' Unlike the coordinators of Primary Medical Care, Child Health and Palliative Care, he made no mention of any particular strategies for teaching this attitude, and unlike the attachments named so far in this section, it appeared that teaching patient centredness was not so central a goal in Dermatology, as he went on to add, *'it's not something we primarily focus on'.*

The coordinator of the Genito-Urinary attachment mentioned some of the specific patient centred attitudes the attachment attempted to teach students to help them work in what he clearly saw as a challenging and sensitive specialty. These attitudes included understanding what he called, *'the weaknesses of human nature'* and demonstrating *'being non judgmental'.* He felt this was particularly important in Genito-Urinary Medicine, where:

> *we explain how easily your own discomfort can rub off, however well you think you are controlling it, and the patient will clamp up if they see you are uncomfortable.*

The coordinator of the Orthopaedics attachment mentioned the teaching of various aspects of patient centredness, including listening to patients and using them as the main source for information when making a diagnosis and assessment. He was particularly adamant about the need for students to learn to '*treat patients with respect*', and said that if students did not, '*we come down on them like a ton of bricks*'. For him, dressing appropriately and looking clean and tidy were an important aspect of showing sufficient respect:

> *certainly, in terms of talking to patients and treating them properly, we do wax quite hot about students turning up in inappropriately dressed, dirty hands, dirty face and all that sort of stuff. That doesn't really show your patient proper respect, if you turn up looking like a tramp, so to speak.*

The coordinator of the Eye attachment also said that they attempted to teach an attitude of *'being courteous to the patient'*. He too was liable to reprimand students who did not look the part:

> *if I see them standing round the bed with their hands in their pockets I go and call them out, because that absolutely winds me up.*

He had however a rather nice, self deprecating story about how one attempt to teach students to show respect for patients had backfired on him:

> *I was very firmly put in my place the other day because, quite rightly, the student going up to this 90 year old said, "I'm David, could I know your name?" And she said she was she was Bessie Smith. So he said, "Well Bessie", and I said, "Hang on; do you think a 90 year old really likes being called Bessie by somebody they haven't met before?" ...so I developed that theme, rather pompously perhaps, and then I said, "Well let's put it to the test", and we turned to Bessie Smith and said, "What would you like to be called by the student?" "Bessie" she said, and they all fell about laughing, and I was wild. But I think it is considerations like that that they have got to think through, and not just taking patients' feelings for granted.*

Teaching positive attitudes to 'challenging' patients

Four courses had written aims which involved tackling the negative attitudes that students were thought to have towards difficult, unattractive or, in medical jargon, '*heartsink*' patients.

The Clinical Foundation course aimed to teach students the generic skills of:

> *How to cope with negative aspects of doctor/patient contact, the problem of the difficult patient and the difficult doctor.*

The medical curriculum book stated that the third year Psychiatry attachment aimed *'to*

develop an attitude of confidence and professionalism in dealing with the mentally ill', while the book also said that the fifth year Psychiatry attachment aimed to help students, *'have some appreciation of prevailing attitudes to mental illness including stigma and how these attitudes affect services.'* The coordinator of the fifth year Psychiatry attachment confirmed that they were trying to remove stigma and teach *'positive attitudes'* towards the mentally ill in the third and fifth year:

> *becoming comfortable with the notion of mental illness, de-mythologising a lot of the stigma that they* (i.e. the students) *inevitably come with....attitudes both to patients and to psychiatrists.*

He said that the way in which the students responded to such attempts to change their attitudes was variable. Some students came with *'already a very good insight and a very positive attitude'* while others had *'enormous misunderstandings about psychiatry'* and were *'so far behind really that they are never going to catch up, and you just hope you can move them along just a little bit'.* Echoing the concerns he expressed, which we have already noted under holism, about the extent to which students generalised from their experience in Psychiatry, he felt that, although the attachment did manage to shift students' negative attitudes, any change tended to be temporary, *'if you go back and talk to them 6 months later their attitudes have all shifted back'.* He felt this was because of the surrounding medical and surgical context:

> *the environment that they work in, the acute medical and surgical wards where people make a lot of derogatory remarks about psychiatric patients, and so it is a very temporary attitude change at that stage....If they go from us to 10 weeks of surgery, with a very hard line consultant who has a very biological approach, then I think it soon reverts.*

The coordinator of the Geriatric attachment talked at length of the shifts he hoped to make in students' attitudes towards the elderly. He intended that, through the attachment, students would come to feel that elderly people were interesting:

> *they have had rich and varied lives, because they have had long lives, so they are actually interesting people to talk to.*

Similarly, the coordinator of the Palliative Care attachment talked of his efforts to help students to overcome their fears of talking to patients with cancer *'without scaring the living daylights out of either of them'.*

Empowerment

- ***This thesis will examine the extent and nature of teaching about empowerment approaches in the medical curriculum, and at staff understanding of and attitudes towards this issue.***

In the course of the interviews, only one medical member of staff, from Primary Medical Care, used the precise term '*empowerment*':

> *Well patient centredness is absolutely key, but like so many things we use cliches, you know, 'education' or 'empowerment', or 'patient centred' and the thing is what does that cliche mean?*

It thus appeared from the sense of what he said that the word was in use in Primary Medical Care, and it may be of interest that this teacher juxtaposed the term *'empowerment'* with *'patient centredness'*. Apart from this, the actual term *'empowerment'* was by two other people, both of them non medical. One was the specialist in specialist in health promotion, who said she attempted to touch on empowerment models in her one lecture on health promotion, but that medical staff did not use the concept of *'empowerment'*. The other was a teacher of Psychology, who said that in *'the smoking practical'* they tried to get students to identify the models they were using, and decide whether they were *'empowerment'* models or *'dependency'* models.

Although not themselves using the term *'empowerment'* very much, the models of holism, patient centredness and communication could in many ways be seen as linked with empowerment. This issue will be looked at in more detail in the discussion chapter.

Summary of patient centredness

Patient centredness in the sense of empathy with, and respect for, patients was nominated by the overall coordinator of the whole course, the first two years and the third year, and 22 of the 24 clinical courses as a key attitude they intended their course to teach. It appeared as an aim for the course as a whole, and for two of the basic science courses, for Psychology and Sociology. It was most apparent in the clinical elements, where it appeared to be a dominant theme, being talked of, positively and at length, by most of the clinical staff interviewed. It was evident in the business of teaching students to take a history, which routinely took into account the patient's psychological state. Patient centredness was seen as absolutely central to Primary Medical Care, and very important in Obstetrics and Gynaecology, Geriatric Medicine, Child Health, Palliative Care, and Genito-Urinary Medicine. Psychiatry, Geriatrics, and Palliative Care were said to make special efforts to teach students positive attitudes to patients with whom they might find it difficult to empathise or whom they might find worrying.

The term *'empowerment'* was used three times in the course of the interviews, twice in connection with patient centredness.

COMMUNICATION

- ***This thesis will attempt to assess the extent and nature of teaching about communication in the medical curriculum.***

Link between communication, holism and patient centredness

This section will look at communication in general, and at communication with patients in particular. Students own communication with one another and with professional colleagues will be looked at in the next chapter on roles and relationships.

One teacher from Primary Medical Care saw the concepts of *'holism'* and *'patient centredness'*, using these very words, as linked both with one another, and with the practice of *'communication'*:

> *..a more holistic approach is, I suppose, the answer. I always find it is difficult to define things like 'student-centredness' and 'patient-centredness', except by looking at people in a broader context. There are a lot of bits which go with that, which are about teaching communication skills, looking at difficult consultations, and bad news, and things like that.*

Many staff appeared, implicitly or explicitly, to share his linkage of the concepts: the three issues were often discussed together. For example the overall coordinator of the medical curriculum saw the quality of the *'communication'* offered by the doctor as the barometer of the patient centredness of his or her underlying attitudes:

> *Where there is bad communication it very often results from a certain type of attitude. If, for example, a doctor's attitude is "I know best. You listen to me", then clearly the patient would experience a particular attitude and object to it, to their not being listened to, and that's where complaints will arise. So one tries to educate people in not adopting that attitude, demonstrating what will happen if you do. So I think when you tackle communication actively, attitudes towards patients will come out very quickly.*

So it seemed as if, for some staff at least, the way in which the holistic perspective and a patient centred attitude could be achieved and manifested in practice was through good communication.

Communication in the course as a whole

Table F18 summarises the state of teaching about communication in the medical curriculum. It is clear that it was seen as having considerable importance, being mentioned in relation to 19 of the 38 course elements, and receiving particular prominence in the clinical elements.

The overall coordinator of the medical curriculum felt that *'communication'* was a major priority for the medical curriculum, being *'something which is so fundamental to the practice of medicine'*. He said he did not wish to restrict discussion of *'communication'* to *'communication skills'*, saying:

> *I slightly tend to shy away from the phrase 'communications skills', as it makes it like learning to take blood pressure.*

So this section will take its tone from him, and use the more general term *'communication'*, and only use the phrase *'communication skills'* where that was the phrase used by staff, orally or in writing.

According to several coordinators, including the overall coordinator of the medical curriculum, communication had, like nutrition, achieved the status of being a *'vertical thread'* in the curriculum, which meant that it was seen as running through many courses in different years, and was, in theory at least, monitored and coordinated. The overall coordinator of the medical curriculum summarised the feelings of many interviewed when he said:

> *Communication's one of these things which is too important to be bolted on. It's really got to be all teachers.*

He felt that the state of teaching across the curriculum on the issue was *'gradually improving'*, an assessment also expressed by both the teaching coordinator of Primary Medical Care and a previous Psychology coordinator. The latter thought that, *'actually the students are aware that they need to know this, which is a good development'*.

Communication in the basic sciences

The overall coordinator of the first two years said that *'teaching communication skills'* was an aim for the two years as a whole, and confirmed that staff were trying to develop it as a vertical thread. He did not think that this had yet been achieved. He felt communication was well taught in the first term, the course he coordinated, when the students visited a person with a disability in their homes, but he regretted that it did not appear to be followed up in subsequent terms.

Table F18 *'Communication'*[1] in the medical curriculum[2]

Course	In medical curriculum book[3]	According to staff in interview (negative instances in brackets)
Course as a whole	Aim *'to communicate effectively and sympathetically with patients and their relatives or friends'*	Said it was fundamentally important, should run right through the curriculum Had status of being a 'vertical thread'
Basic sciences/ Years 1 & 2		Said it was a vertical thread through all courses, in theory (but did not think it well taught, except in Foundation term)
Term 1/ Found.	Sociology lecture: *'Doctor-patient communication'*	Said it was taught through students visiting people with disability in their homes
Psychology		Said they decided not to teach it, as group too big. but thought it vital in general
Sociology	Lecture on *'Doctor-patient communication'*	Saw *'doctor-patient communication'* as part of what they were teaching
Clinical attach Year 3 and 4		Said it was a key aim for clinical years but thought teaching of it would be *'patchy'*.
EPC PMC	Aim *'to enable students to begin to learn to communicate with patients...'*	
CFC	Aim *'communication with patients and relatives and other professionals'*	Reported a major teaching input, teaching students basic clinical communication skills
PMC	7 of the 10 competences concerned with communication: *'- establish an effective relationship with the patient* *- listen attentively to patients..* *- find out why the patient came that day* *- conduct an appropriate physical exam. and communicate with the patient about it* *- explore the patient's ideas about their problem and its management* *- be able to describe and explain to the patient the management of at least one chronic and one acute illness* *-discuss lifestyle changes with patient in an appropriate manner'*	All said this was the main goal of their teaching All third year seminars included communication skills teaching, especially: - 2 'OSCEs' which taught and assessed communication skills, using actors - Seminar on *'breaking bad news'* PMC staff trained others, especially on CFC
O&G		reported that they included role play with actress

Medicine	Methods *'further teaching will concentrate on communication skills, dealing with patients' relatives...'*	Said taught through osmosis and role modelling
Child Health		Said they taught students to realise that it involved: communicating through 3rd party and that communicating with *'team'* including relatives
Palliative Care	Aims *'to enable students to:* *- communicate effectively with ill patients and their families* *- break bad news* *- examine issues of communi. How to do it better and get it wrong less often'.*	Said central goal of course was talking to patients and relatives about cancer
Psychiatry	Aim *'the student should learn to interview psychiatric patients and their relatives confidently'*	(Said did not want to be exclusively associated with it, so had cut back teaching on it) Psych. staff trained others, esp. on CFC
Geriatrics	Aims - *'students will:* *- consolidate skills in communicating with patients* *- learn methods for communicating with patients who are deaf or cognitively impaired'*	Reported a session on communicating with deaf people
Project		If the student chooses it
GU		Said central goal of course was teaching students to talk about sex without embarrassment and take clear and reliable sexual history
Neurology		Said taught through osmosis and role modelling
Year 5		
Child Health		As for third year
PMC		As for third year
Psychiatry		Said they expected students to be competent at it (said they did not want to be exclusively associated with it, so had cut back teaching on it)
Total (from 38 potential elements[4]	8	19

Notes

1. *'Communication'* does not include references to *'history taking'* on its own.
2. This table only notes positive instances. If a column is blank, or a course is not listed, it can be assumed that the entry would have been negative.
3. As Public Health Medicine, Psychology and Sociology did not have an entry in the medical curriculum book, their course handbooks have been used instead.
4. *'38 potential elements'* refers to all the categories used for this particular analysis, which were the 31 courses, the course as a whole, 1st and 2nd years, the 3rd and 4th year, the 5th year, and Public Health Medicine, Psychology and Sociology.

There was one lecture on '*Doctor-Patient Communication*' in the Sociology course in term one. One teacher of Psychology said that those who taught Psychology had made a conscious decision not to teach communication themselves, as they felt that this was not possible with so many students and they would need further resources to do it well. She herself had also turned down an offer to teach communication within Palliative Medicine, due to the pressure of other work. She felt however that it was a very important issue to teach:

> *I think a really good communication skills course is absolutely vital for our students, and would be appreciated by them.*

One of the teachers in Public Health Medicine felt the balance between the courses of the first two years was wrong, '*far too detailed*', and without enough on '*communication*':

> *At least half of them are going to be GP's, and nobody is teaching them communication skills.*

So it would appear there was not a great deal of teaching about communication in the basic science elements of the course, which at least two staff regretted.

Communication in the clinical elements in general

Like holism and patient centredness, communication came into its own in the clinical elements. The coordinator of the third year saw it as a key aim for the year as a whole. As table F18 shows, it was named as a written aim, or mentioned under methods for 7 of the 23 clinical courses, and mentioned by 14 clinical coordinators.

The coordinator of the third year felt that *'teaching communication skills'* across the third year as a whole was, as she had said of holism, *'patchy'*:

> *they get a little bit in their clinical* (i.e. the Clinical Foundation Course) *.....if you went round with some students on their average firm, Medicine and Surgery, it's all about "What's that lump, what's that spleen?" not "What did the patient tell you? How did they feel about it?" So its about as high on people's priorities as it is for most clinicians in a big hospital....*

She felt that some of the teachers were positively inspiring for the students in their teaching of communication:

> *you get some superb like* (name of coordinator of Palliative Care) *who's, fabulousa, and of course, they come back fired up, they love it.*

However she felt that, in general, this Medical School was lagging behind other Schools in teaching about this issue.

Several staff remarked that, in the past, communication had tended to be seen as the sole province of Primary Medical Care and, to some extent, Psychiatry. Members of both of these groups were however adamant that it needed to be taught more widely. As the Chair of Primary Medical Care said:

> *I think that the main thing that we keep articulating is that this is not something that is particular to Primary Care, everybody should do this..... It is pointless if you only listen to people in General Practice.*

The coordinator of the third year Psychiatry attachment had a similar view:

> (communication skills) *should be taught by everyone as part of each attachment. ....We don't like to regard ourselves as being the sole teachers about communication skills.*

The coordinator of the third year Psychiatry attachment reported that, as a result of these concerns, Psychiatry had actually cut down its teaching on the issue. Staff from both Psychiatry and Primary Medical Care had taken an active role in moving the issue into other courses, most notably in the Clinical Foundation Course, a development which will be discussed later.

Communication in Primary Medical Care

Congruent with their concerns for holism and patient centredness, all staff in the Primary Medical Care group said they saw communication as absolutely fundamental to their specialty. One of them said Primary Medical Care had indeed always taught about communication but they were now more *'up-front about it, in saying that it is the most important thing.'* The Chair of the group felt that teaching about communication in Primary Medical Care was not new. She made the same point that one of her colleagues had made about holism and patient centredness, that the value of it was now being clearly supported by research evidence:

> *we are getting more and more evidence to suggest that these various things make a difference...so the evidence base is stronger.*

Several staff in the group talked at length about the nature of the communication skills they taught. All agreed that they were about listening to the patient, involving them in the consultation process and coming to a shared view. As one described the skills:

> *I think essentially they are listening skills, and I suppose sharing skills: the ability to formulate your own ideas in a language that the patient can understand, and to involve them in that process of formulation if you like, shared formulation.*

The OSCE was essentially about the demonstration of patient centredness through effective communication with the patient. The student was graded solely on their ability to communicate with the patient about the problem: the checklist through which the student was assessed concentrated on the students' ability to discover the patient's beliefs, needs, motivations and emotional state, to reflect them back to the patient, to ask open rather than closed questions, talk to the patient in terms that were congruent with their state of mind, and their apparent level of understanding. The student was not assessed on their ability to make a specific diagnosis, and not expected to move on to issues of patient management at all, as staff considered that it was too early in their clinical career for this to be appropriate. After the role play, and when the student had commented on what they thought they did well and badly, the feedback given to the student by the 'patient' as to the degree to which they felt the student as 'doctor' understood them was seen as being of the utmost importance. All staff took great pride in this OSCE, and the words of one stood for the opinions of many:

> *The OSCE ..almost seems enshrined in good practice and is universally liked and* (gets) *rave reviews..... Its the gold standard, if you like, in our teaching'.*

The group's teaching coordinator remarked that the basic communication skills involved in talking to patients were now so accepted that both staff and students felt the time had come to deepen them:

> *they* (i.e. students) *are getting more adept at it, and can go further and do more difficult things. In my group yesterday, they said that they would like in the OSCE for the actors to actually crank the volume up, as I put it. One of them perhaps to become aggressive, one to become quite anxious, to see how they could cope with that. I have just rung the actors this morning, and they are happy to do that.*

Another, the one who we noted earlier was concerned that students simply learned to play the game of being patient centred, wanted very much to develop the group's teaching about communication. He was concerned that cynical students could pretend to manifest '*superficial skills,*' and wanted to move on to teaching the deeper attitudes that make the consultation '*technique invisible*'. He said that otherwise, *'it is very easy for them* (i.e. the students) *to pick up a technique orientated approach, and actually miss the whole point'.*

Communication in the Clinical Foundation Course

The Clinical Foundation Course ran for the first two weeks of the third year, and was taught by staff from all the clinical specialties. It was viewed as a major step forward by many that communication now represented one of the two basic aims of the course, and much effort was reported as having been put into developing the teaching of communication skills, with two staff, one from Primary Medical Care and one from Psychiatry, leading the initiative.

These staff had been instrumental in producing a video tape and using it to train other tutors. The activity was similar to that used in the OSCE of the third year Primary Medical Care attachment, and the ethos and principles of student centredness and patient centredness were the same. It involved working with students in groups of three, looking at videos students had made of themselves with a patient, and giving feedback to the students on their performance in an organised way. One of the staff from Primary Medical Care described the tutors' training which, he said, mirrored the activity staff were then expected to engage in with their students:

> *getting them* (i.e. the clinicians who acted as tutors on the course) *along and, for an hour and a half workshop, discussing communication skills, showing them the video, showing them that they could give feedback in a sort of positive way, and then getting them to role play it, and then seeing how they felt about it.*

He felt tutor participation in the training for the exercise had been hampered by interference from their other priorities, but that all in all it had been fairly successful:

> *they are all terribly busy. The Clinical Foundation course isn't a high priority, it is the wrong time of year for them, most of them, because it is the middle of their conference season. But out of 55 tutors, 20 have been on the workshops: we ran three.*

He went on to say that they were now involving the trained tutors in teaching other staff.

Communication in Palliative Care

Communication also appeared to be central in the Palliative Care attachment. The coordinator reported that students who came to them said that they had had little practice in talking to patients with cancer:

> *some wards say they're not allowed to talk to patients with cancer, and things of that sort, so they lack terribly confidence in communicating with them.*

He said that teaching students to talk easily and comfortably to patients with cancer, and to talk to their relatives, was thus one of the main aims of the course:

> *item number one is for them to find out what it's like from patients to have cancer, to be with cancer, what its like for relatives to cope with it, and so forth. How to talk to patients with cancer without scaring the daylights out of either of them, the student or the patient.*

As in Primary Medical Care, the attachment was said to encourage students to listen to patients and their stories rather than to take a formal medical history: the coordinator said that way students found out what actually matters to the patient. He echoed the thoughts of

the coordinators of Geriatric Medicine and Dermatology, already noted in the account of patient centredness, when he said that the priority for the patient might well not be any kind of physical symptom:

> *I'm more interested in their stories than their histories, because they tell me so much more. I go through it, and we come out with a list of physical symptoms because I am a doctor... They tell me all their physical problems, and I say to the patients in front of the students "And what's the biggest problem?" "Well the thing I am really worried about is how my wife will cope."*

Like one of the teachers in Primary Medical Care, he was concerned about the shallowness of some communications skills teaching, remarking that the students thought they had *'done breaking bad news'* through having had one session on it in the Clinical Foundation course. He thought that *'real communication'* was far more complex and difficult:

> *how to communicate with the patient; how to negotiate with the patient what you are going to do and why, and checking out with them, negotiating, checking out with the family and then communicating with colleagues. Once you start talking in those terms I think it is actually very difficult to do well. And so this bland word 'communication' is thrown out as a sort of label you can stick on your chest,* (but) *real communication is phenomenally difficult to do well, and there's an awful lot of poor communication that goes on.*

He gave a lovely example of a patient, who had impressed on students that being the object of insincere communication can be unbearable:

> *the patient we had for the medical students the other day said, "When a certain nurse came on the ward it was hell really, because I had to lie in bed all day with my eyes closed". And the students said, "Why?" He said, "Well, if she saw me, she would rush over and say "Are you all right? Do talk about it". And he said, "I couldn't bear it". So that is the communication that the world sees, but the real communication I think, is difficult.*

Communication in Psychiatry

In one specialty, Psychiatry, both the third and fifth year coordinators said they had consciously cut down on the teaching of communication skills. The fifth year coordinator said that, although they *'expect the students in the fifth year to be able to handle an interview, even with a difficult patient, quite competently and sensitively'*, they no longer taught the skills themselves. *'We slightly play it down these days, and I have actually reduced the amount of the communication skills teaching we do in Psychiatry'.* He felt that for them to teach communication skills risked identifying these skills with just this specialty:

If Psychiatrists teach communication skills, the students get the message that communication skills are what you need if you are going to be a Psychiatrist.

This he thought was the *'wrong message...it makes us and the GPs a breed apart'*. For him the answer was to:

get the Physicians and Surgeons and Gynaecologists involved in teaching about communication, because they are all doctors and need to build communication effectively.

Echoing some of the concerns expressed by some staff from Primary Medical Care about the image and status of their specialty, he said he felt that the previous emphasis on communication skills had caused the students to tend to see Psychiatry as a content-less, *'touchy-feely'* specialty:

I have certainly had this said to me by students .. "Well, I don't understand why I failed". And you say, "Well, that is because you don't know enough". And they say, "But I didn't think there was anything to know about Psychiatry; I didn't think there were any facts"... And if you get seen as too `touchy-feely', people think it is all just about being nice to people, and they don't realise that there is actually a core of knowledge and skills that they need to have.

However he went on to reflect that he was not entirely comfortable with Psychiatry's decision to cut down on teaching communication skills:

it is difficult, because I think in an ideal world you would give them (i.e. the students) *as much as possible everywhere. But when nobody else is doing any at all, and to be frank we also again had workload/manpower problems which weren't helping....so it is slightly a cop-out, and we do worry a bit.*

Communication in the other clinical attachments

The Genito Urinary attachment also apparently prioritised teaching about communication. This coordinator said that, for him, teaching students about communication, rather than about diseases, or even about individual patients was the main goal. He said that the attachment raised sensitive and taboo topics, and that this was the only part of the course where the students could learn to, *'talk about sex with patients without feeling embarrassment'*:

they very rarely see a patient who is prepared and expected to give a sexual history, and to do that in any other part of the hospital, in any other part of the course, could be difficult. So it is a great opportunity for them to actually sit down and talk about sex with a patient.

It appeared that students were taught some of the basic skills in taking a sexual history in a detailed and directed way:

> *after seeing one or two histories, we try and encourage a student to take a history from a straight forward patient, and during that history we want a very detailed sexual history, when they last had sex, how long they have been together, what they use for contraception, when the last other sexual partner was. And we then go through the history together with the student, and find out the areas that have been avoided or missed, how vague the student was, because often if you are uncomfortable you can be very vague. We then tackle that, and we talk about the importance of being specific, particularly if it is going to be contact-traceable and all the rest of it.*

The third year Child Health attachment was also said to prioritise communication, and was said by the coordinator to raise some specific issues to do with communicating with children. As we have already noted, under patient centredness, a key goal of the attachment was to get students to feel comfortable communicating with children, by encouraging them literally to get down on their hands and knees and see the world from a child's point of view. Like the coordinator of Palliative Care, this coordinator also mentioned that the *'teamwork'*, which he saw as fundamental to Child Health, meant that students had to learn to communicate, not only with the individual patient, but with *'all other people who are involved with the patients'* such as other professionals, and parents. He remarked that students needed to be made aware that communicating with parents about children was communication through a third party, and thus raised issues of interpretation.

The third year Obstetrics and Gynaecology attachment also apparently carried out some specific teaching about communication, through one role play session, using an actress. The coordinator felt this was an opportunity to see how the students reacted in a situation that was potentially *'quite difficult or delicate'*. Unlike Primary Medical Care, it appeared that this specialty was content to keep its teaching of communication quite basic. The coordinator said that tutors were looking for *'simple generic consultation skills'*, such as appropriate seating, eye contact, body language, and the use of appropriate reassuring words. He reported that the students appeared to appreciate the session, *'it does seem to get quite good feedback, so they seem to find it useful.'*

As we have seen when we looked at teaching about 'challenging' patients, the entry in the medical curriculum book for the Geriatric Medicine attachment said that the course aimed to teach students *'methods for communicating with patients who are deaf or cognitively impaired.'* The coordinator reported that the attachment taught one session specifically on *'communicating with deaf people'*. Other than that, he felt that communication skills teaching permeated the specialty, through role modelling, or as it is sometimes called, *'teaching by osmosis'*, but he said that they took special care to try to ensure that the

students were exposed to good examples:

> *You tend to know who are good role models and who are not, and we do try and make sure they are exposed to good ones.*

Several other attachments appeared to rely solely on this traditional method of '*teaching by osmosis*'. The coordinator of the Neurology attachment said they relied on students picking up communication skills, though role modelling, and more specifically through the questioning of the consultant, and they did not teach theses skills formally. The coordinator of the third year Medicine attachment said that his attachment also took such an incidental approach, but mentioned that he was worried about the resultant quality of the teaching:

> *it's probably taught very badly...most consultants feel that they teach them* (i.e. communication skills) *but whether they do effectively or not I'm concerned about, I guess.*

Summary of communication

Communication was very much linked in the minds of staff with the concepts of holism and patient centredness. It was mentioned in relation to 19 of the 38 course elements, and in particular to 14 of the 24 clinical elements. Several staff felt that it was essential that it be taught across all the specialties.

Systematic and thorough teaching about communication was reported as occurring in Primary Medical Care and Palliative Care, where staff were keen to start deepening the skills they taught. Primary Medical Care particularly emphasised communication as a central goal, especially through the OSCE, where students were taught through role play with feedback. Psychiatry had consciously cut down its teaching in this area in order not to be seen as 'soft'. Staff from Primary Medical Care and Psychiatry had developed a training programme for clinical tutors teaching on the Clinical Foundation Course, which involved training tutors to give feedback on videoed consultations by students, working in small groups.

Genito-Urinary Medicine, Child Health and Geriatric Medicine attempted to teach the specific communication skills needed to meet the challenges of these areas. In the Neurology and the Medicine attachments, students were taught 'by osmosis', i.e. through role modelling, but the coordinator of the Medicine attachment expressed concerns about how adequate an approach this was.

CHAPTER FIVE

FINDINGS

PART THREE:

ROLES AND RELATIONSHIPS IN MEDICINE AND THE STUDENTS' OWN HEALTH

ROLES AND RELATIONSHIPS IN MEDICINE

- ***This thesis will look at the extent and nature of teaching about the role and power of medicine, in relation to society, the other professions and patients, and staff attitudes towards this issue.***

CRITIQUE OF MEDICINE

Critique of medicine in the medical curriculum as a whole

Table F19 attempts to summarise the coverage of the role of medicine and/or a critique of medicine in the medical curriculum. As the notes to the table say, this table includes all references to the *'role of the doctor'*, the *'role of medicine,* a *'critique of medicine'*, *'critical thinking'* and '*evidence based medicine*' in the medical curriculum booklet and/or in the interviews.

Critique of medicine in Public Health Medicine and the psycho-social sciences

As table F19 table shows, two courses, the Foundation term and Early Patient Contact, Primary Medical Care had aims which mentioned the role of the doctor.

According to the course outline, the contribution of Public Health Medicine to the Foundation term included lectures on *'The roles of medicine'*, *'Philosophy of science and medicine'*, and two on *'Origins of medicine'*. The teaching coordinator described these as looking at *'the role of medicine and the history of medicine and philosophy of science.'* The Chair of the Public Health Medicine group delivered these lectures, which he said included a review of some of the critiques of medicine:

Table F19 *'Role of medicine/ 'critique of medicine'*[1] in the medical curriculum[2]

Course	In medical curriculum book[3]	According to staff in interview
Basic sciences/ Years 1 & 2		
Term 1/ Found.	Aims: -*'to begin to understand the role of the doctor and other health professionals in society'* - *'to gain an understanding of the scientific method'* PHM lectures on: *'The roles of medicine'* *'Philosophy of science and medicine* *'Origins of medicine' (2 lectures)* Sociology lectures on: *'Doctors, patients and professions'* *'Non-orthodox therapies'*	
Term 2: Cardio-resp.	PHM lectures on: *'Study design' (2 lectures and a practical)* *'Evidence based medicine'* *'Critical appraisal' (practical)*	
Term 5 Endocrin., Human Repro and Nephro.	Objectives *'experimental evidence is included so that the student is able to assess the veracity of the mechanism proposed'* Sociology lectures: *'Doctors as managers'*	
Public Health	See term 1 and 2 above, and SBOM below	Chair of the group said the lectures looked at critiques of medicine *'Teaching critical thinking'* key aim of the group.
Sociology	Lectures on: *'Doctors, patients and professions'* *'Non-orthodox therapies'* *'Doctors as managers'* *'Consumers or patients? involving the patient in the NHS'*	Said the lecture taught students to *'take a more critical approach as to the role of medicine and doctors in society'*
SBOM (year 3)	PHM lectures on: *'Health care evaluation'* (3 lectures) *'Introduction to evidence based medicine'* *'Systematic review of RCTs'*	3 lectures on *'how to evaluate the health services,* (and) *a little bit about evidence based medicine'*
Clinical elements		
EPC Primary Medical Care	Aim *'to identify the different perceptions of the role of the doctor and different expectations of heath care'.*	

CFC	Aims (students acquire) - *'a scientific attitude to clinical practice'* - *'a critical attitude to clinical practice'*	
PMC		All said their approach was a contrast to traditional medicine: more emphasis *on 'social science'* and on *'holistic'* and *'patient centred'* goals 2 said they attempted to teach 'critical thinking 1 said they tried to teach the *'evidence base'* for practice
Geriatrics		Said a joint seminar with students from other health professions turned into an unintended critique of medicine
Medicine	Aim (students) *'demonstrate a logical approach to diagnosis* (and) *be able to form their own conclusions'*	
Palliative		Said the approach was a contrast to traditional medicine: more emphasis on *'holistic'*, *'patient centred'* goals and on *'emotion'* and *'intuition'* rather than facts and diseases
Psychiatry	Aim (students will) *'develop a critical and scientific approach to clinical practice in psychiatry and related disciplines'*	
Project	Aim (students will) *'learn how scientific data is collected and handled, and in particular the sources of variability...develop a critical attitude which will help them...assess the merits of the innumerable innovations in treatment which are proposed and embarked upon so enthusiastically*	*'Get experience in research basics'*
Total (from 38 potential elements)[4]	**10**	7

Notes

1. Includes references to *'role of the doctor'*, *'role of medicine, 'critique of medicine'*, *'critical thinking'* and *'evidence based medicine'*.
2. This table only notes positive instances. If a column is blank, or a course is not listed, it can be assumed that the entry would have been negative.
3. As Public Health Medicine, Psychology and Sociology did not have an entry in the medical curriculum book, their course handbooks have been used instead.
4. *'38 potential elements'* refers to all the categories used for this particular analysis, which were the 31 courses, the course as a whole, 1st and 2nd years, the 3rd and 4th year, the 5th year, and Public Health Medicine, Psychology and Sociology.

> *One of my lectures is a lecture about the critiques of medicine, and it goes down very well. I actually take them through about a series of about 8 or 9 increasingly radical criticisms of what is wrong with medicine, looking at Illich, the Marxists, the feminists, the anti-psychiatrists and so on.*

He felt he could get away with it '*because I'm a doctor and can do that*'. He pointed out however that he had to tackle it in a tactfully oblique manner, telling the students that although they might not agree with the criticisms, they needed to know that they were being made:

> (I tell the students) *"You need to be aware that people do say these thing". Which is a bit of a cop-out, but every time I feel them beginning to get edgy, I say, "Well you may not like this but you have to know that people are out there saying this about doctors and you need to be able to handle that, and to understand what the arguments are." So they start listening again.*

He suggested that this approach was in contrast to that which had been used by some Sociologists, including some in this Medical School, who had alienated the medical students in their lectures by '*going in with all guns blazing*':

> *the content of the Social Sciences has often been strongly critical, not in a very useful and positive way, of the medical profession, which I think the students at that stage can find difficult.*

He gave an example of '*a Sociologist* (who) *came in and slammed the medical profession to such an extent there were several complaints afterwards to the Faculty Office*'. He thought this was inappropriate:

> *you just can't do that, because you have to realise they* (the medical students) *have chosen this as their profession, and they need to be cajoled into accepting that there are other ways of looking at it, not just sort of a full frontal attack.*

The Sociology input itself included a lecture on *'doctors, patients and professions'* given in the first term which, as we have seen directed students to look at their role as professionals, and consider the power and esteem they held. The Sociology coordinator, not himself the person who was accused of 'blazing guns', thought that students *'need to take a more critical approach as to the role of medicine and doctors in society'*, but concurred with the Chair of Public Health Medicine that the approach taken needed to be a tactful one:

> *I don't think what one does is to go out there and do crude 'doctor bashing'. I think that is inappropriate and....medical Sociology has been in the business of*

doing this in the past I think.

Critique of medicine in the Geriatric attachment

Students were also said to experience a critique of medicine in one of their clinical attachments, but by accident rather than design. The Geriatric Medicine attachment had apparently made an effort at multi-disciplinary teaching, described thus in the medical curriculum booklet:

> *multi-professional teaching about professional roles, teamwork and medical problem solving. For a whole day medical students join with podiatry, nursing, OT and physio students for workshops based around clinical cases.*

The coordinator said that unfortunately the other students had used it as an opportunity to *'slag off'* the medical students:

> *we put in a multi-disciplinary study day where we are getting loads of different disciplines together, OT, Physio, Nursing, again something of an act of faith. It was poorly rated by the students, and very interestingly, the reason is that a lot of people, like nursing students, use it as an exercise for doctor bashing, so they come in and really just generally slag off what a load of tossers they think doctors are, "Medical students are a waste of space", and all the rest of it.*

He felt that, in theory, it was useful for medical students to learn that other professionals do not see them as *'the greatest gift to the world'*, but that as the intention of the exercise was *'reinforcing ideas about interdisciplinary working, mutual respect'* it had clearly backfired, and he was reluctantly thinking of dropping it.

As we saw when we looked at holism and patient centredness, two of the clinical specialties, Primary Medical Care and Palliative Care felt that their approach stood in contrast to what they saw as traditional medicine. In both cases, they felt they took an approach which could be described as more psycho-social, holistic and patient centred, in contrast to what they saw as the scientific and objectifying approach of mainstream medicine. Of the two, Primary Medical Care placed more emphasis on the social science approach, while Palliative Care placed more emphasis on emotion and intuition.

CRITICAL THINKING

Critical thinking in Public Health Medicine

As table F19 shows, two basic science courses, namely the Foundation term, and term five, the Endocrinology, Human Reproduction and Nephrology Systems Course, stated in writing that they aimed to teach students to think critically about what they were learning.

Evaluation of the health services and evidence based medicine were also reported as being taught in the Scientific Basis of Medicine course, according to the overall coordinator of the medical curriculum.

> *and in third year there's this Scientific Basis of medicine course ...last year we had three afternoon sessions, where we taught how to evaluate the health services, a little bit about evidence based medicine.*

It seems likely that all these references were to work in Public Health Medicine, as only staff from this group mentioned teaching this issue. Indeed, teaching about being critical, being able to evaluate, and basing practice on evidence were issues which appeared to be very close to the hearts of the staff from Public Health Medicine, and which staff from this group saw among their key teaching aims. As table F19 shows, the group taught two lectures and a practical on '*Study design*' which included a look at RCTs, a lecture on *'Evidence based medicine'* and a practical on *'Critical appraisal'*. Critical appraisal was mentioned as aims by 5 of the 6 interviewed from this group. One of the group summarised what this approach was aiming to achieve:

> *to make them* (i.e. medical students) *able to critically appraise literature, to see the relevance of Public Health Medicine and to sow seeds of doubt when they actually go on to clinical firms, that everything isn't as black and white, it is a very grey world.*

Similarly, the Chair of the group said:

> *I would like them* (the students) *to be more critical, more prepared to weigh up the evidence for what they are doing.... so they don't accept that just because they were taught it, and Mr So and So and Dr So and So do it, it's the right thing to do. And that they really do understand how to check whether the evidence from the trials is there, and if not, how good the evidence is. And if they are doing a test, what is the predicted value of that test, and is it really worth doing?*

He wanted the students to be as critical of what he called a *'social science'* point of view as they were of a bio-medical perspective, although not more so:

> *the students ... need to have a grasp of the way social scientists think about the world, and be accepting and critical and about those ideas as well, in the same way as they are accepting and critical of what they are taught by other people.*

Another member of the Public Health Medicine group felt that this critical approach should, in theory at least, be of great interest to medical students:

> *it's clearly very directly relevant to the medical students and their future*

careers as doctors, to see the wood for the trees and what works and what doesn't.

But he felt that the concentration by the medical curriculum on the lecture method made it difficult to teach Public Health Medicine's basic aims of being critical:

I don't think we've succeeded in implanting that (i.e. thinking critically)*...I think it's something you really can only discuss in a small group work. There's always somebody in the group with a polarized view and you can bring out those types of issues there, but it's difficult in a didactic lecture.*

One member of staff from Public Health Medicine consciously linked *'critical thinking'* and *'prevention'*. He felt that the two issues complemented one another, and should be a thread or core skill that runs through the whole of the curriculum:

there should be some things that we nail down as a central thread that should have more time, and there should be some core skills in different areas, or ways of obviously looking at how you can identify what's wrong with the patient, or I would argue at how you look at preventing things. Critically looking at evidence. What's the evidence for doing something this way rather than that way? What's the evidence to stop it in the first place? What's the secondary prevention and tertiary prevention?

Two staff from Public Health Medicine were optimistic that medicine as a whole was moving in their direction in general and towards evidence based practice in particular. As the group's teaching coordinator put it:

I think the whole movement of evidence based practice and evidence based medicine is clearly on the up. We had to take account and move with the times...I think one drive has been the GMC report (presumably *'Tomorrow's Doctors*) *which has been a major boost to Public Health.*

Both felt that Public Health Medicine was centrally placed to lead this movement.

One of them, the teaching coordinator saw potentially a strong link between critical thinking and clinical medicine:

It's is all about sowing seeds of doubt, so that when they come on to the medical firm, they have actually learnt to think.

Critical thinking in the clinical attachments

As table F19 shows, three courses, the Clinical Foundation, the fifth year Medicine attachment and the third year Psychiatry attachment aimed to teach critical thinking. It was also mentioned verbally by two of the staff from the third year Primary Medical Care

attachment, one of whom talked of the need to teach the *'evidence base'* of their clinical practice. The fifth year Medicine attachment linked critical thinking with a key task of clinical medicine, that of teaching students to make a diagnosis: its written aims included the statement that students were:

> *expected to demonstrate a logical approach to diagnosis, be able to form their own conclusions and generate a plan of investigation.*

However, this potentially interesting link between critical thinking and diagnosis was not one that staff made during the interviews.

Critical thinking in the fourth year project

Critical thinking was ostensibly one of the major *raisons d'etre* of the fourth year Project. In the medical curriculum booklet, the written aims of the project stated that it was intended that students should:

> *learn how scientific data is collected and handled, and in particular the sources of variability....it is hoped that students will develop a critical attitude which will help them...assess the merits of the innumerable innovations in treatment which are proposed and embarked upon so enthusiastically.*

The feelings of other staff about the value of the Project in general, and its contribution to critical thinking in particular appeared to be mixed. Three of the clinical staff were positive about it. For example, the coordinator of the two Child Health attachments felt it taught the students *'how to use the literature and how to assess situations more scientifically'* and was in his opinion invaluable for students' future careers, and *'the gem...a superb part of the course'*. In contrast, 4 of the 6 coordinators of the fourth year clinical attachments, whose courses abutted the project were very negative about it, seeing it as a waste of valuable clinical time.

One member of staff from Public Health Medicine thought that in practice each student only really got a view of the one area in which they conducted the research, and wished that the medical school took the opportunity of the project to teach the students more about research in general, including about critical reading:

> *I think it would be better if there was more structure around research methods, and more developing skills around critical reading and the process as much as the detail of the particular area. Because I think you can get into one tiny area and not have any sense of the sort of overview.....* (the students should learn) *if you do a very detailed experimental study, how does that fit into the broad spectrum of evidence information?*

The status of critical thinking

All members of the Public Health Medicine group expressed concerns about the image and

status of critical thinking and evidence based medicine in the minds of clinicians. Two of them remarked that staff in Public Health Medicine had hoped to link more closely with the clinical attachments to teach critical thinking in general and epidemiology in particular, but that to date their overtures had not met with a very warm response. One of these two expressed the view that clinical staff were at best neutral about critical thinking, which he found disappointing:

> *I wouldn't say that Southampton was a leading light in terms of things like evidence based medicine... We wanted to try and get more involved with the clinicians ...but overall there's not a huge thrust pulling by the clinicians.*

The other agreed that clinicians were not favourable towards either the Public Health Medicine's offers to collaborate, or towards the evidence based approach in general:

> (name of lecturer in Public Health Medicine) *has been trying to make liaisons with the obstetricians to talk about evidence-based... there again, the obstetricians themselves have got the huge great Cochrane data-base, and it had been banned from the unit until a couple of months ago. They do not practice, they do not implement the results of all of what is known to be best. So they are hardly likely to be wanting us to adopt that sort of spirit, and wanting us to teach with them.*

He contrasted the McMaster approach of problem solving with the traditional approach of UK medical schools, such as this one, of '*list learning*' and '*facts*'. He concluded:

> *I can't really see a way round that, but we do need to move towards the problem-solving agenda and evidence-based medicine agenda.*

He felt that the problems with the status of critical thinking went deep into the nature of the medical establishment, who do not like their taken for granted practices being questioned:

> *It perpetuates that mould. So we run medical education very much as an Edwardian establishment and it takes a couple of decades for changes to come through. That's why evidence-based medicine is thought of as being controversial here. How dare you question the practice of a consultant? If they're a consultant they know what's best.*

So it was clear that critical thinking and evidence based medicine were not thought by those in Public Health Medicine, who were the most interested in teaching it, to have yet been accepted by the clinical staff.

Evidence based medicine had not apparently met with great approval from the students. The overall coordinator of the medical curriculum felt that such process oriented skills would always tend to be regarded by students as low status and had what we have seen already was a much maligned characteristic, of being seen as common sense in a curriculum

driven by facts:

> (the medical curriculum is) *very fact oriented still. However much it's integrated, it's integrating facts, so it's still about facts.... There isn't a lot of critical thinking there...The facts are almost too easy to understand...but how much we don't understand, how much we don't know, how much these concepts are difficult, and the problems, there is not enough of the more abstract ideas about. The students tend to see what we teach as common sense, but I don't think it really is common sense. I think there is a lot more to it than common sense.*

TEACHING ABOUT, AND IN, THE COMMUNITY

- ***This thesis will examine whether there was a shift to teaching more about Primary Medical Care and the community in the medical curriculum, and, if so, what staff thought about this development.***

The community in the course as a whole

Table F20 attempts to summarise work on the community in the medical curriculum.

The community was referred to, somewhat vaguely, in the medical curriculum booklet's statement of aims for the course as a whole:

> *to provide knowledge and understanding of...human relationships in the context of...community and society.....*'

The community in the basic sciences

Work in or about the community did occur in the first two years, but was apparently infrequent. The coordinator of the first two years reported that students almost never left the School of Biomedical Sciences in which they were taught for all of their preclinical studies: the only exception was the three visits to patients home in connection with both types of Early Patient Contact. Early Patient Contact, Human Reproduction, did indeed claim that one of its aims was *'to help students develop a perspective of the relative importance of hospital medicine and the community services*'. The coordinator of the first two years said that a few students might take a trip out to collect some data for the research which students were asked to do for the '*think tank*' seminars.

The community was referred to in some of the lectures in the first two years. In Public Health Medicine, the specialist in health promotion looked at '*community wide interventions*' in her lecture, and two others staff said that they used community based data as illustrations in their lectures. All these three staff expressed a wish that the discipline move to a more community based approach in practice.

Table F20 *'The community'* in the medical curriculum[1]

Course	In medical curriculum book[2]	According to staff in interview (negative instances in brackets)
Course as a whole	Aims: *'to provide knowledge and understanding of...human relationships in the context of...community and society'*	(Consensus was that the move to more community based work was imminent, but that at present there was not much of it)
Basic sciences/ Years 1 & 2		Said student might collect data in the community for their 'think tank' exercises.
Term 2 Cardio-Resp	Sociology lecture: *'Lifestyle, community and health'*	
Term 5	Sociology lecture: *'Primary Care and the NHS'*	
Public Health		3 staff said they mentioned *'the community'* in their lectures
Sociology	Lectures on: *'Lifestyle, community and health', term 2* *'Primary Care and the NHS'* term 5.	
SBOM		Said they *'discuss the more general aspects of that disease in the community...and how it relates to the management of the patient'*
Year 3 and 4 Clinical elements		(Coordinator keen on *'getting students into the community'* but said had not happened much yet)
EPC HR	Aim *'to help students develop a perspective of the relative importance of hospital medicine and the community services'* *Postnatal visit with the Health Visitor, to meet up with the patient and her baby in the home environment'*	Confirmed that the students visited a patient in their home with a health visitor.
EPC Primary Medical Care	Method and contents '(students) *meet a GP who will introduce them, in pairs, to a patient with a chronic illness..In terms 2 and 3 the students are introduced by the GP to three further patients.*	Confirmed that the students visited a patient in their home with a GP.
CFC	Aims, *'attitudes: ...a community perspective'*	

PMC	Timing *'the course consists of thirty half day sessions, of which twenty three are spent in general practices'*	All 5 interviewed said they were involved in teaching in the community by definition. Teaching coordinator said their aim was to *'give students the idea that there is life outside the hospital.'* One said some GPs make special efforts to involve community based work. Said they involved community based GPs in running seminars at the University.
GU		Said an aim was to teach students *'a bit about ...the responsibilities of the doctor and the interface between managing the individual and managing the community..'*
O&G		Said they sometimes took students to antenatal clinics and family planning clinics in the community. Said they involved community based staff in the teaching.
Geriatrics		Said they made great efforts to get students out to other hospitals, clinics and aid centres. Said they involved community based staff in the teaching.
Child Health		Said they involved community based staff in the teaching.
Dermatology		Said they took students to clinics.
Psychiatry	Objectives - *'knowledge: become familiar with... community settings* - *attitudes: develop a family and community perspective of* (sic) *mental health problems'*	Said that students spent a great deal of time in the patient's home, and some went on mental health act assessments in outpatients or at a Police station, and attached themselves *'to a community psychiatric nurse on their visits'.* Said they involved community based staff in the teaching.
Project (not a clinical attach)		If the student chooses it.
Year 5	*'The final year is..spent largely in hospitals outside Southampton..with the Regional Consultants.'*	
Child Health		Said '*most of the District General Hospitals are usually one trust between community and hospital, and so many of the consultants are Community Child Health Physicians anyway, so they give them quite a good community flavour in their teaching.* '

Psychiatry	aims '*to become familiar with the components of a comprehensive psychiatric service...services for children and adolescents, the elderly, the mentally handicapped, ...domiciliary visits, day hospital, clinical psychology, community nurse service..*'	Said they were working hard to increase community based work, from a low and variable base.
PMC	Aim '*to understand how the presentation and management of medical problems differs with a community based perspective'.*	
Total (from 38 potential elements)[3]	9	15

Notes

1. This table only notes positive instances. If a column is blank, or a course is not listed, it can be assumed that the entry would have been negative.
2. As Public Health Medicine, Psychology and Sociology did not have an entry in the medical curriculum book, their course handbooks have been used instead.
3. *'38 potential elements'* refers to all the categories used for this particular analysis, which were the 31 courses, the course as a whole, 1st and 2nd years, the 3rd and 4th year, the 5th year, and Public Health Medicine, Psychology and Sociology.

The coordinator of the Scientific Basis of Medicine said they taught students about, if not in, the community:

> *we will discuss the more general aspects of that disease in the community, as it were, and how it relates to the management of the patient, and what the patient might think about it.*

The community in the clinical attachments

8 of the 15 clinical courses in the third and fourth year, and 4 of the 6 in the fifth year, reported that they made some reference to, or use of, the community.

All the coordinators of all the clinical elements were asked about the extent to which they involved students in working in the community. All said that they had considered it. 6 said they found it impractical at present.

Two attachments were said to have made a deliberate decision not to send students away from the General Hospital, for educational reasons. The coordinator of the Orthopaedics attachment said that they had tried sending students out to other hospitals but it had not worked well: they felt that the other large local hospital did not teach, while when sent to hospitals *'out in the sticks'* the students tended to '*skive*'. The coordinator of the Genito Urinary Medicine attachment said they did not take students into the community '*because unfortunately the community is where most examples of bad practice there are*'.

In contrast, all the staff interviewed from Primary Medical Care saw themselves by definition as community based. For example when the teaching coordinator was asked about his group's teaching *'in the community'*, he looked mystified and asked *'as opposed to....?'* He went on to say that one of the key aims of the attachment was to *'give students the idea that there is life outside the hospital.'* Both the medical curriculum book and all in Primary Medical Care confirmed that all the teaching outside of 7 core seminars was taught by GPs in the community, with each students going out for half a day a week for 23 weeks, and being placed with three GPs. The teaching coordinator said that some GP teachers already made special efforts to include more community based experience on these placements:

> *GPs will have a variety of things that they may do with the students. Like, I know some GP's will rotate them round all the different members of the primary health care team, they may go to visit a pharmacist, the undertakers you know the whole thing. Also, seeing people in their homes, being involved with the social services as well, that sort of thing.*

Outside of Primary Medical Care, 7 examples of community based work were cited, as table

F20 enumerates. All were said to form a very minor part of the course: the overall impression was that students spent the bulk of their time in hospital, being taught by hospital consultants.

In the fifth year the students left Southampton and were placed in hospitals and with GPs across the Wessex region. Three staff, the coordinators of Surgery, Child Health, and Psychiatry said they felt this made the courses more community based than those of the third year.

The consensus among the 10 staff who spoke at any length on the issue was that a move to a community based approach had certainly not happened yet, and that the Medical School was in fact currently doing less community based work than ever.

Shift to the community

Although currently, teaching in or about the community was not common, 10 staff commented on what they saw as a coming move in this direction. It was reported that the idea of the shift was being very actively discussed across the Medical School, a committee had been set up to examine it, and it was now a question of '*when and how, rather than whether*' as one member of staff from Primary Medical Care put it.

It was felt that the main reason for this shift was that patients were now in hospital for such a short time that students were currently not learning the clinical skills they needed. As the overall coordinator of the third year said:

> *So already the changes in the health care system are actually having an impact on how our students learn their clinical skills, and it seems to me they need actually to go where people have got more time and patients are sitting there longer to talk to...* (at the moment the patients are) *unconscious, they don't even wake up... so the community based stuff is going to be increasingly important.*

4 coordinators, from Child Health, Geriatric Medicine, Primary Medical Care, and Public Health Medicine commented on what the shift might mean for the aims and content of the curriculum, and interestingly all 4 saw the move towards community based work as being concerned with and supporting an increased emphasis on prevention and/or health promotion and/or on holism. For example, the coordinator of Child Health said that '*part of the community exposure that they get is prevention, is health education, surveillance.*' The Chair of Primary Medical Care reported that an effort which they had made a few years previously to teach a form of Early Patient Contact on *'anticipatory care'* had foundered for lack of local practices, a problem which she thought a decentralised approach would solve, as students could be spread further afield. The coordinator of the fifth year Surgical attachment indicated that this shift from the hospital to the community was already making

students more conscious of the need to understand the social contexts from which the patients came:

> *Patients are getting home when previously they would have been in hospital. We have patients with major sectional surgery who are home in five days, so this raises all sorts of other issues for the General Practitioner in terms of pain control and this sort of thing and clearly the house that the patient goes back to. They've got to be able to understand whether it's suitable or not for such a patient.*

So, although there was not much work in the community at present, a shift to community based work, and to Primary Care, was thought to be on its way, in a way that some thought would be supportive for prevention and health promotion, and the holistic perspective that underpinned them.

TEAMWORK AND MULTI-PROFESSIONALISM

- ***This thesis will examine the extent and nature of teaching about the role and status of other health professions in the medical curriculum.***

Teamwork and multi-professionalism in the course as a whole

Table F21 summarises coverage of team working and multi-professional practice in the medical curriculum. It shows that these issues were mentioned as a course aim, in relation to the course as a whole and to 5 clinical courses, namely the Clinical Foundation Course, the Geriatric, Palliative Care and Psychiatry attachments in the third year and the Primary Medical Care attachment in the fifth year. It may also be recalled that, in answer to the question *'what kind of attitude do you hope the students will learn on your course?'* multi-professionalism and teamwork were mentioned 4 times between them.

The overall coordinator of the medical curriculum thought that respect for other professions was a very important attitude for the course as a whole to convey to would be doctors:

> *if you become aware of what other professionals are doing....that helps you to have some respect for what other professionals are doing... I also think it helps you to realise that there are other things outside what a doctor may do, which may be important to the patient's future.*

Teamwork and multi-professionalism in the basic sciences

In the basic sciences, such work appeared currently to be infrequent. The coordinator of the first two years reported that they were thinking of introducing some multi-professional teaching, combining the medical students with occupational therapy and physiotherapy students, but had not done so yet. As coordinator of the Foundation term, he also said that they had attempted to prepare the students for their future work in multi-professional teams

Table F21 *'Teamwork'* and *'multi professionalism'*[1] in the medical curriculum[2]

Course	In the medical curriculum book[3]	According to staff interview (negative or neutral items in brackets)
Course as a whole	Aims *'to develop appropriate attitudes, including...the capacity to work constructively and courteously with others* *to develop the professional skills necessary:...to communicate clinical information accurately and concisely to...other professionals involved in the care of the patient'*	Overall course coordinator said 'respect for other professionals' was a key attitude he wanted students to learn.
Basic sciences		(Coordinator of first two years said he hoped to introduce more joint seminars with students from other professions.)
Term 1/ Found.		Said students worked in teams to produce joint work
EPC PMC		Said that the students hear about multi professional approach from GPs and patients.
EPC HR		Coordinator of the first two years said the students met other professions on outpatient visits.
Clinical attach Year 3 and 4		Overall coordinator of third year said they students got *'a little bit of stuff... very limited'*
CFC	Aims *- 'skills: communication... with other professionals...* *- attitudes: ...a multi professional perspective'*	Said students worked with nurses.
Child Health		Said teamwork was fundamental to the attachment. Reported that students worked with nurses, audiologists, PTs and other professions routinely.
PMC		Said would see the Primary Care team at work. Extent to which they worked with other professions would vary from practice to practice.

Geriatric	Aim: *'students will practice skills in multi-disciplinary team working'* Methods: *'multi-professional teaching about professional roles, teamwork and medical problem solving. For a whole day medical students join with podiatry, nursing, OT and physio students for workshops based around clinical cases.*	Said they ran a joint seminar with OTs and PTs students, that was disastrous as the other students '*slagged off*' the medical students.
Medicine		Said the students would work routinely with other professionals, at case conferences 2/3 times a week
O&G		Reported teaching by midwives, that was *'very popular'* with students
Palliative Care	Aim *'to understand the role of the multi-professional team in caring for dying patients at home and in hospital and to encourage multi professional team working.'* Methods *'teaching is undertaken in a multi professional way'.*	Reported joint seminars with nurses. Said the students meet the multi-disciplinary team at the hospital.
Psychiatry	Aim '*attitudes: understand the multidisciplinary approach to the assessment and management of mental disorders'.*	Said the students see lots of examples on the wards, e.g. nurses, social workers, OTs Reported optional attachment to community psychiatric nurse
Surgery		Said the students were taught by *'dieticians, stoma therapists and theatre nurses'*
Project		If the student chooses it
Dermatology		Reported *'a bit, not very much'* work with nurses
Eyes		Said *'yes very much so, yes'* Working with nurses, technicians, staff in clinics
GU		Said *the students would see plenty of evidence of teamwork in practice, and* spend time with counsellors and nurses
Neuro		Said would see '*a little*', on ½ day presentations
Ortho		Said students would have a one day in the accident department, and one hour session with Physio: sometimes successful, sometimes not
ENT		Said would see a range of professionals in hearing clinics
Year 5		

PMC	Aim '*to gain a greater understanding of the work of ... the primary care team*'	
Surgery		Said students 'almost certainly' would work with other professionals.
Child Health		Said students would routinely work with other professionals in case conferences
Psychiatry		Said students would meet it routinely, *'everywhere they go'*
Total (from 38 potential elements)[4]	**6**	**24**

Notes

1. Included under these titles are the use of the words themselves, and any mentions of students working with other professionals.
2. This table only notes positive instances. If a column is blank, or a course is not listed, it can be assumed that the entry would have been negative.
3. As Public Health Medicine, Psychology and Sociology did not have an entry in the medical curriculum book, their course handbooks have been used instead.
4. *'38 potential elements'* refers to all the categories used for this particular analysis, which were the 31 courses, the course as a whole, 1st and 2nd years, the 3rd and 4th year, the 5th year, and Public Health Medicine, Psychology and Sociology.

by asking them to work in teams themselves, gathering information for assignments for example. He said the point of this was to emphasise that, in their later professional practice, they would be working as just one member of that team, although he did appear to assume that they would be leading it:

> *we actually stress that they are to become part of a health care team, and not just to be one member of that team; they are going to have to work has a group, perhaps initiating things that others will have to follow.*

Being on an academic course, students were routinely expected to communicate effectively with their teachers in their essays, assignments and examinations, an issue which some staff linked with communication in general. For example, the overall coordinator of the medical curriculum said:

> *Writing a good essay is a good aspect of communication; making sure that your written things are clear, being able to present things to a group of people is an aspect of communication.*

Beyond this routine academic work, four courses had apparently recognised that the skills involved in effective professional communication needed to be taught specifically. The coordinator of the Foundation term said the students had to deliver an oral report in the tutorial groups on the visit to a person with a disability. The students also worked in '*think tanks*', which were group exercises in joint research and poster production, which the coordinator said aimed to encourage teamwork.

Teamwork and multi-professionalism in the clinical elements

Students were also reported as having some opportunistic contact with other health professionals on their Early Patient Contact visits.

The coordinator of the third year thought the students would get little multi-professional teaching:

> *that's mainly 'cos they get very little multi professional stuff really. Again a little bit, they do get a little bit of stuff with the dieticians on their GI module, stoma care nursing, but the multi professional thing is pretty limited as well.*

As we shall see, according to the other coordinators, her assessment may have been a little pessimistic.

In the Clinical Foundation Course the students were reported as spending time with nurses, which the coordinator felt taught them respect for this profession and the roles they play:

> (the students) *see how essential the nurse's role is, what contribution they make to the management of the patient, how important it is for doctors to work closely with nurses, because most of the information that we get, and observations on the patient's health, we get through nurses' observation, who are there all day. They are the people who spend most of the time with the patient, and I think this is quite important that the students realise that they are not just there to give a helping hand, but they have a very important role to play.*

In the clinical attachments, some brief experience of teamwork at least seemed to have become more common than not. As table F21 shows, 16 of the 20 attachments said that the students would meet teamwork and have contact with other professions. As the table also shows, the range of professions the students were said to meet included nurses of various types in most attachments, but also mentioned were dietitians, stoma-therapists, occupational and physiotherapists, counsellors, social workers, technicians of various types, and psychotherapists. The Child Health attachment coordinator also mentioned families and schools. Students were said to experience these professionals going about their daily tasks, on the wards, in clinics, and in case conferences, and in some cases were taught by them.

Most of the coordinators indicated that the experience of teamwork was now routine, as the coordinator of the third year Medicine attachment said, '*just because of the nature of medicine in the 1990s.*' The coordinators of three fifth year attachments, Surgery, Child Health and Psychiatry, felt that students would be even more likely to experience teamwork in their fifth year, although the coordinator of Surgery said there would be '*be a lot of variation*' and was not something he at the centre would insist on.

Student reaction to this contact with other professions was reported as variable. The teaching of a session by a midwife in the Obstetrics and Gynaecology attachment was reported as getting *'a very good rating'*, a fact which the coordinator was pleased about, remarking that medical students are often quite hostile to *'non medics'* teaching them. Similarly, a joint session with nursing in Palliative Care was reported as '*very successful*'. However, the coordinators of the Child Health and the Orthopaedic attachments reported that similar sessions they had run were not popular, and had been dropped. At the other extreme, as we have seen in the section '*critique of medicine*', the session organised by the Geriatric medicine attachment bringing medical students together with students from other professions backfired badly, as it resulted in '*doctor bashing*' by the other students.

Three clinical courses had aimed, in writing, to help students communicate more effectively with their colleagues. The Clinical Foundation course taught '*data presentation: skills in concise written and oral presentation of clinical data*'; the third year Psychiatry attachment helped students to '*learn to present a psychiatric case history and discuss assessment and management concisely and systematically*'; while in the third year Surgery attachments

students were expected *'to be able to communicate their findings in written and oral presentations.'*

Teamwork in the fourth year project

The fourth year project culminated in a one day conference at which all the students delivered 15 minute presentations on the findings of their projects. The coordinator of the fourth year Project emphasised that the students learnt a great deal about delivering formal presentations and public speaking at this event. He also mentioned the team effort put in by those students who organised it, saying it was:

> *a good experience for those people on the committee in terms of management, and co-ordinating and that sort of thing'.*

He also thought that it brought the entire year together, with what he referred to several times as an *'esprit de corps'*, raising the funds needed to pay for the conference and the publication it produced through discos and sponsorship.

Outside of these two examples, no other staff talked of encouraging teamwork among the students, and the impression was that on the whole the course followed the traditional pattern of competitive individualism.

Summary of roles and relationships in medicine

The role of medicine and/or a critique of medicine was a theme that was looked at in 12 elements of the course. Teaching such issues was thought to need careful handling if it was not to alienate the students

The Public Health Medicine group saw teaching the skills of critical thinking and evidence based medicine as a central part of their role, but felt that such an approach received little support, and some hostility, from those in clinical medicine.

Teaching about, and in, the community was touched on in 19 elements of the course, but the consensus was that any coverage of the issue, teaching by community based staff, or placement in the community was infrequent and decreasing, and that students spent far and away the majority of their time working with doctors in the general hospital. Only in Primary Medical Care was community based work the norm. All who commented on the topic agreed however that a shift to community based teaching was inevitable, and imminent, given the increased tendency for patients to spend less and less time in hospital. Some staff saw this move as supportive for prevention and health promotion.

Teamwork and multi professionalism were issues that were apparently covered in several elements of the course, 24 in all, and students were reported as meeting a wide range of

professionals, but again such teaching was reported as representing only a very minor theme within courses. One example of teaching about teamwork seemed to assume that doctors would automatically be leaders of health care teams. Student reaction to contact with other professionals was said to be variable, and one multi-professional seminar, in which medical students mixed with other professions, was said to have resulted in unseemly '*doctor bashing*' by the other students.

Student' own communication skills were explicitly taught in only 4 courses, including three clinical attachments, and there were only two examples of encouraging students to work in teams, so again these issues would appear to have constituted only a minor theme: on the whole the course appeared to follow the traditional pattern of competitive individualism.

THE STUDENTS' OWN HEALTH

- ***This thesis will examine the extent and nature of teaching about, and/or a concern for, students' own health in the Medical School, and at staff attitudes towards this issue.***

Table F22 summarises teaching on the students' own health. It would appear that such issues were of overt concern to a few staff as a pastoral matter, and were touched on in teaching, but were not covered very often, very systematically, or in much depth: few staff had much to say on the subject, despite all being questioned directly about it. As this issue, caused some staff to become critical, their comments will again be more anonymatised than elsewhere.

Concerns with, and teaching about, student stress

The traditional view of medicine as a tough '*initiation process*', which those of the *'right stuff'* survived by virtue of having a robust attitude, could perhaps be seen as reflected in the preface to the medical curriculum booklet. The preface recognised that '*being a medical student involves hard work and can be stressful*', but carried on to say, '*I do not know a single doctor...who does not regard it as one of the highlights of their lives*'. Its advice was simply to '*keep a sense of humour*'.

In contrast to the these optimistic words, the coordinator of one of the systems courses talked at great length and with much feeling about how much he was concerned about the *'stress'* the students were under and the lack of support available to help them cope with it. He felt that the curriculum had deteriorated in recent years, with, as he saw it, insufficient attention being paid to the details that made the course work from the students'

Table F22 *'Students' own health'* in the medical curriculum[1]

Course	In medical curriculum book[2]	According to staff in interview
Course as a whole	'Stress' mentioned in preface	2 coordinators worried about high levels of student stress and lack of concern about it by the medical school.
Basic sciences/ Years 1 & 2		Some opportunistic coverage. Coordinator of first two years dismayed at failure of inputs in Foundation term but keen to cover this issue.
Term 1 Foundation		4 recent inputs on aspects of 'looking after yourself': only one persisted.
Term 2 Cardio-Resp.		As 'guinea pigs' in practicals, taking blood pressure, lung function tests etc.
Term 3 Locomotor		Opportunistic e.g. if student have sprained their leg, they talk about it.
Term 6 Gastrointestinal		Seminar discussion of own experience of alcohol.
Public Health		Mentions of the pill, smoking and diet as examples in lectures
Clinical attach Year 3 and 4		*'Minimally yes, but not enough'* according to the overall coordinator of the third year.
PMC		Seminar on *'breaking bad news'* Opportunistic coverage in seminars One to one opportunistic discussions with GPTs
O&G		The odd 'pointed' student question.
Palliative Care		Concern with student stress and emotional reactions to patients central to this specialty.
Psychiatry		Seminar discussion on anxiety, alcohol and drugs
Electives		Lecture on self care while away on electives overseas.
Project		If student chooses it
Dermatology		Opportunistic student questions Students used selves as 'guinea pigs', examining own skin.
5th year Psychiatry		Discussions of personal security Opportunistic one to one discussions with consultants
Total (from 38 elements)[4]	**1**	**15**

Notes

1. This table only notes positive instances. If a column is blank, or a course is not listed, it can be assumed that the entry would have been negative.
2. As Public Health Medicine, Psychology and Sociology did not have an entry in the medical curriculum book, their course handbooks have been used instead.
3. *'38 elements'* refers to all the categories used for this particular analysis, which were the 31 courses, the course as a whole, 1st and 2nd years, the 3rd and 4th year, the 5th year, and Public Health Medicine, Psychology and Sociology.

point of view. He felt that no-one gave enough time to the students, or was interested in the students as individuals. He felt this had repercussions on the students' health, for example, by providing no-one familiar for them to talk to in times of trouble:

> *what the students have now been told is that if they have a problem they can go and knock on 'the problem person's door'. That's no good, students don't go and knock on doors and say "Excuse me, but I have just had an abortion"... or "Excuse me, my mothers ill"* or *"Excuse me, I am totally depressed." What students do is have conversations with people and then bring it in, or students will talk to people who they have talked to previously.*

Similarly one of the overall coordinators felt that many students had mental health problems about which the medical school was not sufficiently aware. Indeed she felt that, to some extent, this problem was created by the negative and hostile nature of medical education:

> *Your average consultant surgeon doesn't know how to give feedback, except to say "you're an ignorant medical student, you're an ignorant git, I'll humiliate you while I'm at it". I mean that's the only feedback they know how to do, is to trash people. That's what medical culture is, that's what it's like, that's what medicine's like. Its very ingrained in it: don't tell people they're doing well, just tell them they're doing badly*

It was her perception that there was a *'higher proportion of students than ever with major health problems, stress, quite a lot of anorexics, all sorts.'* She remarked that a local consultant who specialised in eating disorders had told her that she would be surprised at the large number of students who came under his care, and that *'the ones that actually get admitted and things are the tip of the iceberg.'* She said she had *'a constant stream of students here ....clinically depressed.'* She was unsure whether things were getting worse or *'whether people are just less stigmatising now'*, but felt it was a problem that in the medical school *'we don't have a baseline'* of data about this kind of thing. She felt that the traditional medical attitude towards stress had to change, and was indeed changing:

> *I think this whole culture of stiff upper lip... and "we don't get stressed" and all that, has got to change. I think it is changing. There are some quite distressed students around actually, and they need to be able to help each other.*

She connected the issue of student stress with that of role modelling by doctors, saying that what she called the *'big issues around the students' own health'* were *'a big area we need to look at...if they're going to look after their patients, they've got to look after themselves first'*.

As we have seen, the Palliative Care attachment was unusual in its emphasis on affect, in recognising that the students' emotional reaction to the potentially upsetting nature of the

specialty was an important issue with which to deal. The entry for this course in the medical curriculum book said it aimed *'to enable students to survive themselves both as students and after qualification'*. In the interview, the coordinator talked extensively about the mental health of both medical students and practising doctors. He saw mental and emotional health as central problems for the medical professional, an issue he raised spontaneously as '*a particular thing I've got on at the moment'*. He felt that a lot of doctors '*are going down like ninepins with stress related illness'* and retiring early, which he thought was *'no kind of answer to those kind of problems'*. He said he had met a lot of doctors who have '*moved into non-clinical medicine because they could not cope with patients emotions and feelings'*, which *'horrified'* him.

This coordinator was keen that doctors have the kind of training which might help them to avoid such burnout. Like the coordinator of the third year he saw medicine as a highly critical profession, and felt that doctors needed to learn to be kinder to themselves and others:

> *We also need in Palliative care, and I suspect in all of medicine, to be generous to our colleagues, which we are not, because the medical way is to carve you to bits.*

He reported that his attachment was attempting to tackle the problem. He said that the course spent a great deal of time exploring the students own feelings, such as their fear of coming on the attachment, their fear of patients with cancer, their lack of confidence, and with surfacing and dealing with their own emotional experiences. He said he tried to help the third year students stop feeling that they had to be perfect:

> (students think that) *they have got to be all things to all men and give everything of themselves. I try to just put this thought in about actually protecting themselves.*

The third year Primary Medical Care attachment was also reported as containing some systematic and planned work on helping students cope with stress, in a seminar (one in a programme of 7) on *'breaking bad news'*. As the coordinator said:

> *we talk about stress, particularly in the context of breaking bad news, and then how they would be feeling about it, and what sort of things they can do to help with that....There will be times when they have seen something, not necessarily in Primary Care, but perhaps something on the wards which they want to talk about. The seminar is an opportunity for that to happen. You know, a terminal case or something... and how they are feeling about it. Because the first month or two, they feel quite disorientated, I think.*

The Chair of the Primary Medical Care group thought that students often talked about their

problems to the GPs with whom they worked:

> *it is General Practitioners who very often are confided in by students who are under stress or this that or the other, and they tell us, and we tell Faculty. I think that is because of the low ratio; they are less threatening.*

The coordinator of the third year Psychiatry attachment also reported that each time the third year course was run, at least one student talked to staff individually about a problem, such as *'their experience of depression, or distress, or problems in their family or friends'*. He reported that this attachment also organised group work, in which students talked about the kind of mental health issues with which their limited experience enabled them to be familiar:

> *because schizophrenia is beyond most student's experience, but drugs and alcohol isn't so much, and depression isn't, and the anxiety disorders aren't, obviously. You usually find in the anxiety disorders, student talk about symptoms of anxiety, they recognise them quite readily and discuss them quite freely, and the drugs and alcohol seminar is always very interesting..... obviously a number of students in the seminars will be regular cannabis smokers so that is always quite a lively discussion actually, about de-criminalisation and things like that.*

The coordinator of the fifth year Psychiatry attachment said that '*care in the community*' raised some issues about safety '*like personal security and communication and record keeping*'. He agreed with the coordinator of the Cardio-Pulmonary systems course, the third year coordinator and the coordinator of Palliative care that the medical school should do more to concern itself with the students' own mental health, telling a story about a student who got as far as her viva in finals, and then broke down, and announced that she was '*depressed*'. He reported that the student said that, *'doing a Psychiatry attachment had actually bought home to her the fact that it was a bit more than normal*'.

So the Palliative Care and Primary Medical Care attachments delivered planned and systematic work on the students' own mental health, while the Psychiatry attachment also looked at these issues, but in a rather more opportunistic way.

The coordinator of the Geriatric Medicine attachment, who was also the Clinical Subdean, reported that a working party had been set up to look at student support and counselling.

Teaching about the students' own health in the basic sciences

There was some evidence that issues to do with other aspects of the students own health, including their physical health, and their security, were touched on sporadically across the course, including in the basic sciences.

It appeared that student health issues that did arise were mostly co-incidental, and to do with minor physical ailments: of term three, the Locomotor Systems course, the coordinator said that the *'students are always interested in the anatomy if they have got a bad knee, sprain this that and the other'*, but said it was *'on an individual basis, we don't seek them out'*.

The coordinator of term six, the Gastrointestinal and Lymphoreticular systems course, mentioned that they touched on the students' own alcohol consumption in '*case tutorials*':

> *because many of them, especially when you are thinking about alcohol intake and that sort of thing, many of the students are actually quite heavy consumers, you get them to talk about that sort of thing.*

The coordinator of the first two years reported that students sometimes worked on themselves or with one another as '*guinea pigs*' in practicals. For example, the coordinator of term two, the Cardio-Pulmonary systems course said that students *'measure their own blood pressures, measure their own respiratory function'*.

In Public Health Medicine, student health issues were said to emerge opportunistically, as examples in lectures. One lecturer said he made a few passing references in his lectures to *'the pill scare (and) their individual perceptions of the risks of contraceptives'* and *'cigarette smoking'*. He contrasted, with regret, this minimalist input with that of another medical school where he had worked, in which students worked on lengthy projects on their own health. Another lecturer from Public Health Medicine looked at the *'students' diets'*, as a way in to getting them to engage with the issues of diet in general. He asked the students to do a *'24 hour recall of their own diet'*, fill in a *'little frequency questionnaire'* and assess their own diet. He said they *'seem to be interested in that'*, but when asked whether he thought they would change their own eating habits as a result, said '*I wouldn't think so'*, remarking that at their age, other things would seem far more important.

A teacher of Psychology, who lectured on the current course, said he tried to teach about the students the importance of self care and of being healthy role models for their patients:

> *I try to smooth their egos a bit, and tell them they are going to be the most credible source of health information in most peoples' lives, and they have a responsibility to themselves as medical students to look after your own cardio-vascular system, partly because you have a duty of care to yourself and partly because you are a role model. I mean, if you are there smoking and with a brandy bottle they won't take you seriously, your patients.*

The coordinator of the first two years was very keen to teach students about their own heath, and had made several attempts to introduce the topic in the Foundation term. One input, by the Genito Urinary Medicine department, was reported as continuing. The GU medicine coordinator said that they had sent, *'one of our counsellors down to talk a bit about sexual*

health', and about student safety, *'as part of looking out for themselves, so they don't mugged when they walk across the Common at 10 at night.'* Another input, by a reputedly charismatic lecturer in Pathology, on *'surviving medical school'*, had looked at *'the problems of substance abuse, alcohol, drugs and so on.'* This was reported by the coordinator of the first years as having gone down quite well with students, but it had been cut it when the particular lecturer could no longer deliver it , as it was thought to depend on his personality and *'with the wrong type of person that would be absolutely dire.'*

Judging by the reported outcomes of two other inputs in the Foundation term, educating students about their own health had not proved to be an automatic recipe for success. We have already noted comments in relation to the Psychology course, from one of the teachers who said that students were more interested in 'sexual health' in Africa than in relation to themselves. Similarly, an input, by the University Health Centre on *'the students' own health issues'* had produced *'feedback from the students* (which) *wasn't as positive as we thought it would be'*. At another session by an outside speaker (from a health promotion department) on *'protecting yourself from HIV/ AIDS' 'the students virtually rioted at it: it didn't go down well at all'*. The coordinator thought perhaps *'the bulk of the students were too immature'* to appreciate it.

The coordinator of the first two years was now unsure how to proceed, *'I don't know quite what to do with it in terms of the health education side'*, but he felt it was an issue *'we need to come back to'*. He felt he would still like the students to learn about *'looking after themselves'*, and in particular to learn about avoiding alcohol, drugs and stress, and what to do when meeting patients with infections, but he reflected that his experience had convinced him that timing was key, *'there are some messages there that I think do need to be fed in: its a matter of judging the right time'*.

Teaching about the students' own health in the clinical attachments

The Chair of the Primary Medical Care group reported that personal health issues sometimes came up in the third year seminars, opportunistically, *'students always think they have got whatever it is, and they sometimes have, and they will sort of stay behind afterwards.'* But she distinguished this from looking at how students could positively look after their own health, which was something that, as was mentioned earlier, she felt they did not do.

The Dermatology coordinator reported that the students were said to initiate discussions about their own skin health, with *'a lot of students end up saying 'Well will you just check this mole of mine?' and things like that'*. The attachment also encouraged the students to examine themselves as *'real life'* clinical examples:

I think it's in some ways what makes it much more real, so I tend to encourage them to do so, in some ways they can learn more from a close examination of their own skin and try to label every single blemish that they have got, rather than look at an abstract thing such as a patient.

In Obstetrics and Gynaecology, coverage of the students' own health issues was reported to be minor and incidental, with the coordinator reporting that, *'women students sometimes ask pointed questions'*.

The coordinator of the third year mentioned a session in the fourth year, delivered by a lecturer in Public Health Medicine, which aimed to prepare students for the health risks they might meet abroad while on their '*electives*'. She reported that, unlike some of the inputs in the Foundation term discussed above, it had gone down well:

(Name) *runs a whole afternoon on their electives on how to look after them, and they talk about transfusion and, tell them about taking their condoms and rubber gloves to Africa, actually that's a really super afternoon, all about how to look after yourself on your elective, ... they think that's brilliant.*

The success of this intervention perhaps reinforced the insight noted earlier by the coordinator of the Foundation term, that in talking to students about their own health, timing is crucial.

Summary of the students' own health

The students' own health received some coverage in the medical curriculum. The mental health of students was a subject of interest to 4 staff, who expressed grave concerns about the level of stress students experienced, and what they perceived as a lack of awareness of this problem by the medical school. Two of the third year attachments, Palliative Care and Primary Medical Care, attempted systematically to teach students about the management of stress in relation to traumatic situations, and the third and fifth year Psychiatry attachments were said to cover student mental health issues opportunistically.

Apart from that, teaching about the students' own health, in both the preclinical and clinical courses, was scattered and opportunistic. In some of the basic science courses and one clinical attachment students were reported as using themselves as subjects of study, for example in measuring their own blood pressure.

Several efforts were reported as having been made to introduce a range of student health issues in the Foundation term: most of these were said to have proved unpopular with students, and only one input currently remained. However a session in the fourth year on the health risks students faced on electives was said to be very popular. It appeared therefore that students were most responsive to such messages if they perceived their

immediate relevance.

In so far as staff conceptualised student health, they appeared to see it as negative and illness/problem centred rather than about positive wellness, and more about mental than about physical health.

TEACHING, LEARNING AND ASSESSMENT

- ***This thesis will examine the attitudes and practices of the medical staff towards teaching, learning and assessment.***

The importance of educational process in the medical school

Staff talked a great deal about educational process, and many of them appeared from their comments to be very 'educationally aware'. For example, when asked how their course had changed in recent years, most staff talked of educational developments, in particular the closer identification of aims and objectives and the development of a more student centred approach.

Southampton had long prided itself on being one of the most educationally innovative Medical Schools. Two staff talked of it as still leading the field in educational change, feeling that others were now following where it had trail blazed, particularly in terms of the development of an integrated curriculum and use of early patient contact. Three staff felt that teaching was of a very high quality, for example, one clinical coordinator said:

> *I don't think TQA has really made a difference to how we teach, because, this might sound an arrogant thing to say, I think we actually teach very well in this medical school...I think the way we teach it is changing. We're certainly teaching it in a more coordinated and more thoughtful manner than we used to.*

However, 7 staff felt that in various ways Southampton was now falling behind other medical schools, as one said, '*other Medical Schools are actually moving ahead of us and I am not quite sure why that is'*. The precise phrase *'resting on its laurels'* was used by no less than 4 staff. For example, one clinical coordinator contrasted his experience of the Southampton curriculum with other medical schools he visited:

> *I have been observing what people are doing in the other parts of the degree course, and feeling that somehow there has been a resting on the laurels with this wonderful unique course that is innovative, but is no longer innovative. Having gone round being an external examiner elsewhere, and seeing that we are no longer innovative, but everybody else is. We are now rather stuck in our ways, and feeling that we have got to do something about it.*

Educational epistemologies

- ***This thesis will examine educational epistemologies, including the relative roles played by knowledge, attitudes and skills in the medical curriculum***

It was clear that many who taught the medical curriculum were, in theory at least, aware of the limitations of the 'transmission of facts' model of medical education. This was an issue that came up time and again in interviews, and also surfaced in the medical curriculum book. For example, in the preface to the medical curriculum book, the Head of the School of Medicine wrote of *'the intellectual and the emotional skills that are needed'*, in addition to knowledge to become good doctors. The coordinator of the first two years said that this part of the course aimed at showing students that there is '*more to being a competent doctor than knowledge'*, and went on to nominate *'awareness of the need to teach attitudes and skills'* as the area that had increased most in the last 10 years.

Table F23 attempts to categorise the written aims of the medical curriculum in terms of their categorisation into cognitive, behavioural and attitudinal domains. Behavioural or skill related terms were used most often, 77 times. The term *'skill'* itself was used 17 times, and the particular skills nominated more than 3 times were '*examine*' (9 times) , '*communicate* (7 times) and *'recognise'* (4 times). A wide range of skills was nominated, as evidenced by the very large number of *'other named skills'* (38) but not none of these appeared more than 3 times each: most in fact appeared only once. So there was clearly a strong intention to teach skills.

Terms that referred to cognitive goals were used next most often, 71 times, of which the most frequently used cognitive term was '*understanding*', used 38 times. The simple '*know*' and/or *'knowledge*' were used only 12 times. Other cognitive terms, such as '*appreciate'*, and '*acquire a perspective or view*', were both used 10 times each and '*be aware*' was used 4 times. So it would appear that staff were aware that there was more to even the cognitive side of medical education than simply teaching students to memorise facts.

Terms relating to *'attitudes'* were used less often, 20 times in all, with the word itself occurring 9 times, and specific attitudes being named 11 times. The specific terms included for example '*enjoy*', *confidence'* and *'satisfaction*'. So it would appear that staff were not as comfortable with the idea of teaching attitudes as they were with the other two domains. The lack of familiarity with the idea of teaching attitudes was reinforced by the surprised and rather confused response of one member of staff from Public Health Medicine, when asked what attitudes he was trying to impart to students:

Table F23 : Number of times terms relating to knowledge, skills and attitudes were used to categorise aims in the medical curriculum book

	cognitive					***behavioral/skills***					***attitudinal***	
	know	*understand*	*appreciate*	*be aware*	*view*[1]	*skill*	*history & examine*	*recognise*	*communicate*	*other named skills* [2]	*attitudes*	*other named attitudes*[3]
Whole course	3	2				2			2	8	2	2
Found. term		7	2			2					1	
Term 2		5	1									
Term 3		2	2	1	1							
Term 4		2										
Term 5		2								1		
Term 6		2	1							1		
EPC PMC								1		3		
EPC HR			1	1	1				1	1		
CFC	1				3	1	1		1	5	1	4
SBOM										1		
Child Health	2				1		1	1				

	cognitive					***behavioral/skills***					***attitudinal***	
	know	*understand*	*appreciate*	*be aware*	*view*[1]	*skill*	*history & examine*	*recognise*	*commun-icate*	*other named skills* [2]	*attitudes*	*other named attitudes*[3]
Primary Care		3					1		1	8		
Geriatrics		1				3	1		2	5	2	1
Medicine	1	1				1	1					
O and G	1	1				1	1					
Palliative		1							2			1
Psychiatry	1	3			3	1	1			4	2	2
Surgery		1				2	1					
Study in depth			1								1	1
Derm.			1					1				
Eyes							1	1				
GU							1					
Neurology		1					1					
Ortho							1					
ENT			1									

	cognitive					***behavioral/skills***					***attitudinal***	
	know	*understand*	*appreciate*	*be aware*	*view*[1]	*skill*	*history & examine*	*recognise*	*commun-icate*	*other named skills* [2]	*attitudes*	*other named attitudes*[3]
Year 5	1					1						
Child Health	1			2						1		
Primary Care		3			1	1						
Medicine						2						
O and G	1	1					1			1		
Surgery												
Total	12	38	10	4	10	17	13	4	9	38	9	11
Total	**cognitive = 74**					**behavioral/ skills = 81**					**attitudinal = 20**	

Notes

1. *'View'* includes *'have a perspective on'* (e.g. *'psycho-social*) and '*have an approach'* (e.g. *'holistic'.)*
2. *'Other named skills'* were those skills named 3 times or less each (e.g. '*assess'* and *'evaluate'*).
3. *'Other named attitudes'* were those attitudes named 3 times or less each (e.g '*enthusiasm'* and '*concern'*).

I never thought about that before. I mean the critical one is obviously the key one, I would like to think actually, I would like to think that they do have a reasonable understanding, no you see that's subject again, I am talking about knowledge.

In contrast, the Primary Medical Care group explicitly used the a tripartite model of 'competency' to underpin their third year teaching, and were aware too of some of the weaknesses of competency based approaches. The remarks of one teacher indicated how helpful they had found the idea of competency:

I don't see how you can run any sort of course without having very clear aims that relate to the knowledge, skills and attitudes you intend to teach, and the competencies seem quite a good way of dealing with that. There are criticisms of competencies, and they can look a little bit like a set of rules or 10 commandments as it were, but I think they are certainly having standards and having an idea of a sort of core curriculum so that we know what we want to get across is essential and then allow more flexibility round the edges, I think that message is still something which is quite a complicated message to get across, to get through to all the teachers.

So it was clear that the medical curriculum intended to teach a great deal more than factual knowledge.

Approaches to learning

Some staff talked at great length and with great feeling about how important it was that those who taught medical students should understand the nature of learning: for example, the coordinator of the first two years talked about the importance of concentrating on learning rather than teaching in setting outcomes.

Seven courses mentioned some version of *'developing students' ability to learn'* in their written aims in the medical curriculum book. For example: the Foundation term aimed *'to develop appropriate learning'*; the Clinical Foundation course attempted to teach both a '*scientific*' and a '*critical*' attitude to clinical practice; the Geriatric attachment aimed that *'learning skills will be enhanced especially seminar presentation, independent study, and problem solving'*, while the fifth year Surgery attachment aimed that students *'should be encouraged to continue their personal education by the use of hospital library facilities.*' The aims of the fourth year study in depth were all concerned with learning, such as *'to read around and investigate a problem ..to think creatively, to formulate and reject ideas, and to do some original work'.*

Several staff made oral comments on the need to teach students how to learn. The coordinator of the first two years said that this was one of the aims of the first two years as a whole, while the coordinator of term two, the Cardio-Pulmonary term said they aimed to

'try and give them (the students) *things that will challenge them intellectually'.* Three of those interviewed from Primary Medical Care saw *'self directed learning'* as an aim for the third year attachment. Three respondents said that the courses they coordinated were aiming at some version of *'broadening the students' vision'*: the coordinator of the Foundation term said the course aimed to show students that *'there is more to life than a lecture theatre'*; while the coordinator of the third year Primary Care attachment said the course aimed at *'making students aware there is life outside the hospital'.*

However there was a widespread feeling that, despite the brave words about the intention to teach broader and deeper processes, that the overwhealming emphasis of the medical curriculum was still on the acquistion of factual knowledge. One of the staff from Public Health Medicine, himself very sympathetic to educational issues, felt that factual approaches tend to be ingrained in doctors, and are hard to shift.

> *I think it's the overall context of our education system, everything is exam-orientated. People like me are trained, are picked and have got here because we are good at reciting lists and we are not good as education facilitators; we are good at standing up and saying 'these are the facts you need to pass this exam'. At least I am aware of that, which a lot of us doctors are not, so I've made a slight transition to the other end. I wish I was a sort of an active learner and every week contemplated what I had learnt, what I should be learning. I wish the way I worked was like that, but unfortunately I have done, what, 5 or 6 postgraduate medical exams, and all of them are reciting facts and regurgitation. It's just a concept that's very foreign to most doctors.*

We have already cited the main evidence for asserting that many staff thought that the curriculum still focused on facts when we looked at 'critical thinking' and so will not repeat it here. It was however a view that surfaced in relation to assessment, and so will be looked at further in a later section.

Methods of teaching and learning

- ***This thesis will examine the methods of teaching and learning employed in the medical curriculum***

Table F24 summarises the distribution of methods of teaching and learning through the various elements, courses and attachments that made up the curriculum. The table has been constructed mainly from staff comments in the interviews, and therefore may be open to some bias and omission, but it may help to give an impression of the range and spread of methods used.

It would appear that the course was still largely dominated by the traditional methods of

Table F24: Methods of teaching and learning used in the medical curriculum

√√ = **used a good deal** √ = used occasionally

Method used (num. of students)	**Lectures** (160)	**Pract-ical** (80)	**Group** (12 -20)	**Small group** (4 - 8)	**Wards and clinics**	**Home visits**	**Using info. technol.**	**Self directed learning/ private study**
Whole course	√√	√√	√√	√	√√	√	√	√√
Yrs 1 and 2	√√	√√	√	√	√	√	√	√√
Term 1	√√	√√	√	√		√	√	√√
Term 2	√√	√√	√	√			√	√√
Term 3	√√	√√	√	√			√	√√
Term 4	√√	√√	√	√			√	√√
Term 5	√√	√√	√	√			√	
Term 6	√√	√√	√	√			√	
EPC PMC			√√			√√		
EPC HR			√√		√√			
Psychol.	√√	√√						
Sociol.	√√	√√						
Public Health	√√	√√	√					
Year 3	√		√√		√	√		√
Clinical Found.	√			√√	√√			√√
SBOM	√√		√√					√
Child Health			√√		√√			√
Primary Care			√√	√√	√ √	√√		√
Geriatrics			√√	√√	√√			√
Medicine			√√	√√	√√			√
O and G			√√		√√			√
Palliative			√√		√√			√

Method used (number of students)	**Lectures** (160)	**Practicals** (80)	**Group** (12 -20)	**Small group** (4 - 8)	**In wards and clinics**	**Home visits**	**Using info. technol.**	**Self directed learning/ private study**
Psychiatry			√√		√√			√
Surgery			√√		√√			√
Year 4	√		√√		√√			√√
Study in depth	√							√
Derm.	√√		√√	√√	√√			√
Eyes			√√		√√			√
GU	√√		√√		√√			√
Neurology	√√		√√		√√			√
Ortho			√√		√√			√
ENT			√√		√√			√
Year 5			√√		√√			√
Child Health			√√		√√			√
PMC			√√		√√	√√		√
Medicine			√√		√√			√
O&G			√√		√√			√
Psychiatry			√√		√√			√
Surgery			√√		√√			√
Total √√ used a good deal	15	11	27	5	25	3		8
Total √ used occasion-ally	4		8	8	2	4	8	24
Total	19/39	11/39	35/39	13/39	27/39	7/39	8/39	32/39

One of the coordinators of a basic science course talked with great warmth and feeling about how important he felt student centredness to be. He said he personally prioritised student motivation and enjoyment over the learning of medical content:

> *My main aims would have been words like `fun' and `confidence' and `enthusiasm' and hoping along the way, that they would learn something. I am not too worried at the end, if there are things they don't remember, or don't know. Because I've always had this feeling that medicine is a five year course, and provided they keep up their motivation and their effort etc etc, then they can make up later what they missed earlier on, within reason obviously.*

This coordinator did not see student centredness as residing innovatory methodologies, *'the methods are traditional, largely traditional, but I would claim student-centred'*. He felt that student centredness was essentially concerned with looking at the course from the students' point of view, and planning it with this in mind:

> *I would mean student-centred in the sense that the course is planned, implemented etc as a process by which students learn medicine. In other words, in everything that we did, I tried to imagine myself as a first year medical student. Where am going to be, where is my source of information, what am I going to do next? Do I know? Has anyone told me? Do I care?*

However he felt very strongly that the course had become much less student centred in recent years, and the students were now treated as an *'anonymous herd'*. It was an issue on which he talked at great length, finally summarising his view:

> *All that was done to try and encourage people to treat the students as individuals, that has gone, completely. Utterly and completely now, there is no monitoring of individual students whatsoever, there is a Student Progress Committee as there always was, but they are totally anonymous.*

So, although in theory the course was attempting to be 'student centred', several who talked about the issue in relation to the first two years indicated that the intention was stronger than the actuality. One of the teachers of Public Health Medicine contrasted student behaviour towards staff at Southampton with the warmer relationships he had experienced at another medical school:

> *The contrast between at UMDS where you are regularly stopping and chatting to medical students who you'd come across a year or two afterwards, whereas here they look the other way, it's quite marked.*

He said he did not blame the students, who he thought would be the same type of young people anywhere, but thought the cause of the problem was *'too many lectures and too many assessments'*.

There were mixed views about whether students would experience the traditional approach of sarcasm and ridicule in the clinical years. One of the teachers from Public Health Medicine thought this attitude still ran through medical education as a whole, characterising *'medicine as a blood sport'*. One the overall coordinators also felt the problem very much persisted, *'it's a part of medical culture, it's very ingrained. Don't tell people they're doing well, just tell them they're doing badly'*. Another clinical coordinator was more optimistic, and felt that in this Medical School it was no longer policy to use such approaches, but concluded that they persisted as a problem in *'pockets'*:

> *there are pockets of it, but I think we are aware of where those pockets are. Actually I don't think any of us, apart from probably the people that are doing it, think it is good, I mean we want to stop it, it's just quite hard.*

Another, who had been educated at Southampton himself, said that he had never experienced such methods, and so assumed the problem did not occur much, apart from *'one or two consultants'*, but added, *'ask me honestly if we have done anything active and I think the answer is probably 'No''*.

On the positive side, some attachment coordinators talked warmly of the need to take students feelings into account, and to be welcoming and approachable. For example the coordinator of the Orthopaedics attachment said:

> *I think it is very important that they are taught they shouldn't see themselves as being a nuisance...they do get taught and we do make them welcome, and they do feel at ease in the department, and they do get quite positive feedback most of the time.*

The Palliative Care attachment was, as we have already seen, very student centred. The medical curriculum book said the course was *'tailored to students' needs , expectations and experiences.'*. Primary Medical Care too was very concerned with students feelings as well as their intellectual development. Staff from this group explicitly conceptualised student centredness as 'starting where students are', although one of the group realised that this was not easy:

> *it* (teaching) *has got to relate to where they* (the students) *are at in their understanding and therefore again it is very difficult. You've really got to find out what they understand, where they are at in taking it all on board.*

He went on to say that there is a very difficult balance to be struck between starting where students are and challenging them enough.

Students giving feedback about the course

Soliciting and responding to student feedback appeared universally to be taken very seriously. As one third year coordinator said '*its pointless teaching people if you're not achieving what you think you're achieving, so it's important to know*'. According to the overall coordinator of the third year, a major curriculum shake up of the third year that had taken place a few years previously had come about as a result of a '*damning report*' written spontaneously by a group of fourth year students, reflecting on their experience, while the shake up of the first two years had made a great deal of use of student opinion in planning the new course.

As part of teaching quality assessment procedures it was now a requirement for all courses that they use a standard University questionnaire to provide student feedback. This instrument was indeed almost universally used, although three of the fourth year attachments which worked with very small groups said they preferred to use more immediate and informal verbal feedback. Several coordinators remarked that the feedback from questionnaires had an immediate and profound effect. As one of the systems course coordinators said:

> *I tell the students verbally 'We are doing this in response to previous years.' And I think they like that. I mean they might grumble at the change, but they like to think that having ticked the boxes that the course is changing as a result.*

Another clinical course coordinator described the real effects of such feedback, *'every tutor gets their mean score for the year, and this is discussed, and anybody who has got a low score is either dropped or changed or has to change themselves'*. Six of the clinical attachments used further questionnaires that they had devised themselves to give them supplementary information.

However some staff had reservations about the use of questionnaires. One coordinator of a first year course felt that, as the relevant evaluative question was not asked at the time of the lecture but included in the questionnaire given out at the end of the term, it was *'fairly useless, as only 30% of students fill it in, and you therefore have no idea what bias that produces'*. Two staff were worried about the effect of the feedback on staff morale, and one of them felt the results could be rather crass:

> *if you drive the whole thing by just the students having a good time you can just sort of make it jolly funny and have lots of jokes, but they don't actually have to learn anything... there is a danger of these crude numerical things rather driving the whole thing.*

Staff talked much more warmly of their use of more direct methods to elicit student opinions, methods which one felt helped students to move beyond *'just whingeing'* to give

more constructive feedback. Students sat on the working parties that informed the delivery of both the first two years and the third year, where they were said to be involved in all aspects of planning and implementation, and give very helpful advice. Two coordinators of basic science courses, the overall coordinator of the third year and the coordinators of two clinical attachments also convened informal groups of students to discuss their term's programme. For example, the third year coordinator said:

> *twice a term we have lunch with that group of twelve students and we just listen and they don't hold back at all. They name names and its great...I always make notes and then feed it back to them and say "is it OK?". So I think actually we get quite a lot of very frank feedback from the students.*

The consensus was that students were very honest and prepared to be very critical, although as one of the overall coordinators pointed out, they tended to be more open with those who coordinated whole years rather than with staff who ran individual courses:

> *They don't actually give feedback to the people that are running the individual bit. As one of the students said "Oh I'd be too scared to complain in Surgery" or "he's going to be assessing me at the end of the attachment, so I don't want to own up" So there's still actually a lot of barriers.*

Three staff mentioned the importance of just 'being around' students and hearing their concerns, for example one said that she was in the dissecting room 8 hours a week, so the students naturally tended to talk to her about their opinions.

Assessment of students

- ***This thesis will examines practices and attitudes towards the assessment of students in the medical curriculum.***

Table F25 summarises the various types of assessment used to evaluate the students' performance. The table suggests that, although students were assessed during the courses and attachments as well as in the big formal examinations, and although there had been some efforts to introduce a broader range of methods, on the whole the methodologies predominantly followed the traditional pattern of formal examinations, multiple choice questionnaires and, in the clinical context, the presentation of cases.

In the first two years, the bulk of the marks were to be obtained in the end of term written papers, usually MCQs, and in the 'spotter' tests during the term. Students also wrote essays, which included psycho-social and Public Health issues. These essays constituted 20% of their marks: students were given a list of 4 titles or so in advance and were then randomly allocated two titles to write under exam conditions. The Faculty had apparently tried to allow the students to write the essays in their own time, but according to one

Table F25: Methods of assessment used in the medical curriculum

Yrs 1 and 2	**Mixture of:** **- Set essays each term written under exam conditions (titles known in advance, but not which one will be written): 20% of marks (except term 1 where it is 10%)** **- 'Think tank': groups of 6 students prepare a poster on a topic they choose and share a joint mark** **- 'Spotters'** **- Written unseen papers: MCQs and sometimes short notes** **- Primary exam bringing all the systems together.**
Term 1	1 essay (10% only of the marks: assessment is lighter to reflect that the students are settling in)
Term 2	2 set essays. Think tank 'Spotter' 1 hour MCQ
Term 3	2 set essays. Think tank 'Spotter' 1 hour MCQ
Primary BM Exam	
Term 4	2 set essays. 'Spotter' 1 hour MCQ
Term 5	(Assessment said to be larger than for the other terms.) 4 set essays 15 minute viva each with clinician and a non-clinician talking to each student 'Spotter' 2½ hour exam: MCQs and short-answer questions
Term 6	2 set essays 'Spotter' 1 hour MCQ
EPC PMC	No assessment but can submit essay for a prize
EPC HR	No assessment
Year 3	**Graded at end of each attachment:** **- Formal clinical assessment (usually case presentation) in most attachments** **- Informal assessment: attendance and contribution commented on by all staff involved** **- A - E grade given on mixture of both. Only relevant if student fails the attachment** **4 set essays throughout the year: 40% of mark** **Viva at end of year: 10% of mark** **Intermediate part one exam at end of the year: 50% of mark**

Clinical Found.	Not formally assessed
SBOM	4 essays, bringing together basic science and clinical subjects
Child Health	Formal: - Present one long case to all of them, this is done as a group sessions, which is marked by one person - Short answers at end of attachment: slides or questions on child development Informal: tutor looks at both formal grades and *'gives overall grade based on their impression of the student as well'*
Primary Care	Have evolved 10 competences which are used for all assessments Informal assessment of attendance: send 3 letters of increasing seriousness if students not there Formal assessment: student performance in the OSCE graded. Performance over whole course fed back to students one to one after the OSCE.
Geriatrics	Informal assessment on attendance, seminar presentation and case presentation. Short MCQ at the end but *'for interest only'*
Medicine	Informal assessment of performance, keenness, attendance Formal viva *'like the viva of finals..valuable dummy run'*
O and G	Assessed on clinical case presentation
Palliative	No formal assessment Informal assessment: attendance figures kept
Psychiatry	No formal assessment: *'dropped through lack of time'* Informal assessment: grade based on *'attendance, clinical skills and ability to get on with other people'*.
Surgery	Informal assessment on their overall performance: attendance, enthusiasm, ability Formal assessment: one long case
Intermediate Part One Exam	
Year 4	**Project: 5,000 word report on original research** **Clinical attachments: assessed for attendance, but not allowed to formally assess, although some have quizzes**
Study in depth	Project: 5,000 word report on a piece of original research. Marked by supervisor and one other internal marker drawn from anywhere in the University.
Derm.	Quiz at the end with a prize for the best Informal assessment: satisfactory or unsatisfactory attendance
Eyes	Self marked quiz with a bottle of claret as a prize Informal assessment: grade on *'did they turn up and were they reasonably competent?'*
GU	No formal assessment Informal assessment: attendance figures kept
Neurology	No formal assessment Informal assessment: attendance figures kept

Ortho	Have end of attachment assessment but not allowed to call it formal Students keep a log book which is checked
ENT	Does not assess students (says could not cope with dealing with extra number of those who fail)
Year 5	**Clinical attachments assessed for attendance** **Some do 'long case' assessment in lieu of students having to do it in finals. If the student fails it, they then do it again in finals.** **Others do not formally assess, but leave it until finals.**
Child Health	Informal assessment of attendance Formal assessment: in lieu of long case in finals. Called *'objective structured long case examination record'* (OSLCER)
PMC	Graded on report written by GP teacher
Medicine	Informal assessment of attendance Formal assessment: in lieu of long case in finals
O&G	Students keep log books which help record attendance
Psychiatry	Informal assessment of attendance Formal assessment: in lieu of long case in finals
Surgery	Informal assessment of attendance Formal assessment: in lieu of long case in finals
Final Exam	

coordinator '*there were cartels forming, where one person did each essay and they passed it round.*'

The most innovative form of assessment in the first two years were the 'think tanks', in which students worked in groups of 6 or so to prepare a poster on a topic they chose, in which they presented a succinct review of evidence, and for which they each received the same, joint grade. Again, the topics might be drawn from any of the basic sciences, including psycho-social science and Public Health Medicine.

The intermediate part one examination, which summatively examined the basic sciences, had been deliberately placed at the end of the third year, in the hope that this would encourage the students to see the links between the basic sciences and their clinical work.

It appeared from the comments of some staff that students found the constant round of assessment stressful, although their concerns also appeared to have lead in some cases to a moderation in the requirements. Talking of the set essays, one coordinator said:

> *They don't like it at all, because obviously they have some that are their favourites that they did well and some are easier than others and of course if they don't get one of those then they are most upset. But they were less unhappy last year than they were the year before when there were a lot more essays. They felt very pressurised.*

One member of staff from Public Health Medicine felt that the amount of assessment was excessive, pointless, and amounted to '*cruelty*':

> *Why do we examine them so often? There's nothing in it for us, nothing in it for them. Why do we keep on doing it? Why not have more concentrated formal assessments after every two years and then the Finals? Perhaps some sort of continuing assessment in the meantime if they find some feedback that's useful, but why are we so cruel to them? This Medical School is crueller to its medical students than anywhere else.*

In the third year, according to the overall coordinator, efforts had been made to reduce student stress about the *'stonking great exam, you know everyone has nervous breakdowns doing it'*, by introducing essays through the year, worth 40% of the overall mark, plus a viva on the essays, which was worth another 10%. Like the intermediate part one, these essays attempted to integrate the clinical and the basic sciences, and again included titles which related to the psycho-social sciences and Public Health Medicine.

Each of the third year clinical attachments formally assessed the students at the end of the course. Some, such as staff from Primary Medical Care, clearly took the process very seriously and were familiar with some of specialist language of assessment:

We have put all our energies into giving them real one - to - one formative assessment, especially after the OSCE, and writing a report on each one of them at the end of the year based on all the reports of their GPS and the seminar leader. We then have to come to an agreement on their summative assessment, which is an overall grade.

In contrast to such efforts, the third year Psychiatry attachment did not formally assess students at all, due to what they perceived as a lack of time, although the coordinator was concerned that this lead the students not to take the course seriously. The overall coordinator of the third year felt that the fact that the clinical assessments did not count towards the intermediate exam, and were only called into play if students failed that examination, was very '*half baked*' and in need of reassessment.

In all the clinical attachments, students were also graded on their attendance. The seriousness with which attachments took this appeared to vary a great deal. Primary Medical Care would send a succession of three letters of escalating urgency to students whose attendance was not satisfactory. The Genito Urinary attachment made sure that students who had not attended were pursued all the way to finals:

So the trouble is that we have been told that they will not be allowed to take finals if they don't do the course, and that is only now working it's way through, so we are getting some frightened fifth year's turning up, saying "I missed my course in the fourth year."

The ENT coordinator was disarmingly frank about what was clearly in his assessment a slightly haphazard process of informal assessment:

The Head of School writes to me with two questions on each student. One: 'Did they turn up?' and two 'Were they reasonably competent?' And of course I can't keep tabs on all 50 because only 7 are in my group, so I have this schema that we fill in, so at least I can be reasonably truthful as to whether the student turned up or not. Of course they change groups and the whole thing becomes extremely difficult: drives my secretary absolutely berserk but we do our best. I mean in terms of assessment you know who the outstanding ones are and the hopeless ones are, so mostly people are all right.

At the far extreme, the ENT attachment had a deliberate policy of not pursuing absent students, which the coordinator said was partly due to lack of time to deal with those who would have to return:

What do you do with the ones who do not pass your assessment?. Do you make them do it again? In which case they arrive in the clinic with some other students, in which case you start increasing the numbers and you detract from the benefit that that group may get.

Although they checked attendance, the fourth year attachments were not allowed to formally assess students, however some did use 'quizzes'. This lack of formal assessment irked

many of them, for example the coordinator of the Neurology attachment felt that being restricted simply to 'pass or fail' on the basis of attendance failed to penalise bad students or reward good ones, and meant that the students did not take the attachment seriously.

Several staff felt that the nature of the assessment had a knock on effect on the rest of the process of teaching and learning. Many staff commented on the way in which the assessment determined students' learning, for example by leading them to prioritise, as the coordinator of the fourth year Genito Urinary attachments said:

> *I would like an assessment of some sort, to make sure that they* (the students) *give it adequate priority of their time. Not that I particularly want to know that they do well, but assessments focus attention.*

The coordinator of the third year Medicine attachment felt that changes in examinations needed to precede changes in methods of teaching and learning, reporting that the attachment had decided not to use an OSCE in their teaching as the students would not have such a test in their final examination. He felt it was important to change finals first.

One clinical coordinator also saw the need for a clear link between course aims and assessment, but felt that there was at present these were insufficient:

> *Our aims are somewhat grandiose and diffuse and aren't really expressed in terms of learning outcomes really. Certainly the assessment bears no relationship to them at all. I think that really is the biggest upheaval here and nationally ought to be looking at how we assess medical students, because once we know what our aims are we have got to assess them and of course once the students know that, that is what they will learn.*

Several staff reported, despite efforts that were, in theory at least, being made to teach the students to take wider and broader approaches, that the thrust of the assessment still about the regurgitation of facts, and that this thus fundamentally affected how students learned. As one clinical coordinator said:

> *I think it's very difficult for an 18 or 19 year old medical student in their first year who has basically got into Medical School and has been selected because they are very good at reciting lists and regurgitating facts, to then instantly be exposed to the different environment and then being asked to take on a self-learning approach. They still want facts, they still want lists, and they are still examined and they are expected to regurgitate lists, so they want to pass their exams. Its their number one objective in life at Medical School: it is a minimum amount of effort to pass the exams. There might be 5 per cent who have a broader approach, mature students who do want other things from the medical course apart from that, but the vast majority want to pass exams and are not interested in the wider aspects. So I think it's a very difficult thing to try to introduce.*

Another remarked: *'I don't know why they have to regurgitate so many facts on so many occasions...I haven't seen a single question yet that makes you think.'*

The assessment of psycho-social science and Public Health Medicine

Psycho-social science and Public Health Medicine were woven into most of the assessments that took place in the first three years, a fact which one of the coordinators of the basic science courses said was starting to *'filter back'* to the students and have a beneficial influence on their attitudes to these subjects.

We have already remarked that the essays set in these years included these disciplines in their themes. Furthermore questions about these areas were also included in the multiple choice questions and the 'short notes' that students completed in their written examinations. One of the teachers from Public Health Medicine gave a summary of the various types of examination and assessment and added that *'Public Health Medicine is all part of those things'*. However, one teacher of Psychology reflected that the succinct style many of the multiple choice and short answer type assessments demanded may have been appropriate for Psychology and Public Health, but did not suit Sociology:

> *It is hopeless in Sociology because in Sociology you need actually more words to discuss it really. You couldn't define what the health belief model is in a few short notes.*

Two staff from these disciplines talked of how pleased they were to be involved as part of the team that examined students in their vivas in the formal examinations. As one teacher of Psychology said:

> *I think it's quite an important message to medical students, that you won't just have somebody there who will ask you about the bones and the muscles and everything, you might well have somebody there who will ask 'How do children manage in hospital: do they have special needs?', and 'Have you ever heard of the NHS in Community Care Act? - and the answer is 'no' (laugh)*

One teacher from Public Health Medicine agreed that such personal involvement in the examination process was vital, not least because the word then got back to the students:

> *When I was doing intermediate vivas, I asked all the students ' How would you work out what services people might require in Southampton for diabetes, and how would you do that?' They all floundered because none of them had read that stuff that they had had all year but I hope the word got back, if you get that bugger* (own name) *he might ask you, so you had better read that stuff in case he does.*

He talked of his fight to ensure that Public Health Medicine, and in particular prevention,

was included in the final examination. He had been asked to supply some questions for finals, but realised when he was in the examination itself that they had not been added:

> *I had a very interesting involvement with a finals exam this year, in that we were asked to supply some questions and we thought a good idea would be to give lots of riders to clinical questions. Give them about 20 to choose from 'And how would you prevent this?' and 'What could be done in the social circumstances to improve the prospects for? Lots of little rider type questions. None of them got put into the exam, nor the full questions that we put in and I suddenly found myself sitting on the Finals Exam Board realising that this had happened and started to fight a strong rear-guard action saying 'Where's the Public Health? There isn't a Public Health section.'*

He went on to talk of his realisation that his fellow clinicians did not understand enough about these issues to examine them:

> *Now the upshot was very interesting because first of all I did have some allies, particularly Psychiatry and one or two others, and we ended up with lots of things like that on paper. But then realised they were all going to be marked by clinicians and I had a stand-up fight with a Professor of Pathology who was arguing that cervical screening isn't a form of prevention because they have already got the disease. I said 'It's secondary prevention'. He obviously didn't know what secondary prevention was, and I realised that we have a fundamental problem. So if you do it by adding a Public Health dimension to the clinical staff (which is the way it should be because it should be integral, it shouldn't be separate, it should be a way of thinking about everything generally) you would then have pathologists marking down a student who says 'this is secondary prevention of carcinoma of the cervix, and as a screening procedure is predictive value is X Y and therefore you should or shouldn't do it in the circumstances, and cost-effectiveness blah blah blah'. And he would be marking all this down because he hadn't understood it.*

So he now felt that, if Public Health issues were to be effectively examined, it was going to be necessary to educate his fellow clinicians:

> *I raised this with the Medical Education Committee and how we are going to deal with that. And the answer may be that we have to give model answers for them to work from which might be a good way of training them but it is in their hands how they mark it in the end and they could ignore what we say and if they don't like it, and some of them don't.*

The importance of teaching

- ***This thesis will examine the importance of teaching in the Medical School.***

Several staff reported that much effort had been put into staff development. A medical education development unit had recently been established, with two members of staff who were both described as very active in grassroots staff development. Many staff reported

attending what all described as 'very helpful' workshops run by this unit.

Some groups were putting effort into their own staff development programmes. For Primary Care it had for some time been a major enterprise, with regular evening training meetings for their GP teachers and regular in house workshops for the University staff. Other departments were starting to find such meetings useful, as the coordinator of Child Health described:

> *My colleagues were feeling that they were losing touch with what was happening* (in medical education) *so they were quite interested to have some updates and some discussion and some further contribution to the evolution of the programme, so that is how it started. And it is working very well, I have to say, I am very pleased with it. I mean it is a variable feast in terms of the numbers who can turn up, but we regularly get 8 to 10 people coming and it is has now become a worthwhile venue for people to come and discuss and contribute.*

However there was a general feeling that teaching developments are happening despite rather than because of University support. Teaching was seen as being squeezed, or even squeezed out, by other pressures and other priorities, fitted in among other things, done on the cheap, and done by people who are not really meant to be doing it or paid to do it.

An overwhelming number of staff voiced the view that it was research, not teaching, that counted in the University as a whole and in the Medical School in particular, and that the former was pushing out the latter in a way that many resented, but most saw as inevitable. As one put it *'it's a second rate activity, teaching is something that we have to do.'* The following quotation, from one of the overall coordinators, is fairly typical of sentiments expressed by a wide range of respondents:

> *I fear that in our brave new world in Southampton becoming a research lead institution, that teaching is going to have less status, its going to have less teeth... And I think that malaise will spread to all staff, which is regrettable.*

One felt that this was related to a rather elitist sense of teaching as a low status activity:

> *So there are all sorts of structural things that push against teaching being given the importance and relevance it should have, not least of which is slight snobbishness. You know, that's for the old Polys to do, to churn people out like a sausage machine. 'We are intellectuals here in the University, and the students get in the way of that' sort of thing.*

At the time of the research few staff apart from the overall coordinators and the Chair of Public Health Medicine appeared to have heard much about the teaching quality assessment exercise (TQA). Among those who commented on it, some felt that it would not have the clout to resist the domination of research. As one overall coordinator said:

I fear that the TQA will be seen to be a hoop through which we jump but as long as you manage to jump through it reasonably intact there will be no bonus marks for actually doing well in it.

However, the Chair of Public Health Medicine was more optimistic:

I think that (the emphasis on research) *will change when the teaching quality assessment thing suddenly hits the University and suddenly all the emphasis will be the other way for a short while as we flurry round trying to get good scores on that as well.*

Several staff felt that money and resources for the development of teaching relied too much on sources outside the University, most often from the region. For example, Primary Medical Care used money from the health region to pay for staff development seminars, locum payments for GP teachers attending evening training meetings, and even to pay actors to act as simulated patients in their mainstream third year teaching. Similarly the Public Health Medicine group was almost entirely financed by outside research funding and regional funding, and yet non University funded staff carried out much of the mainstream teaching on the undergraduate programme. Such cross subsidy was the cause of some resentment, as for example is evident in this next quotation:

that's why (name) *is being forced to back out* (of teaching). *Not that he really wanted to, but the University isn't paying him so why the hell should he do all the teaching? If he's doing that he not doing other things he's getting his dosh for. So it would be crazy. I don't know about other Faculties but I think something like half the teaching that's done is done by non-University-funded people. So that the research people are subsidising the teaching to a huge extent.*

Summary of teaching, learning and assessment

Many staff appeared to be very interested in and aware of the process as well as the content of medical education. A few felt that the Medical School was still in the forefront of educational innovation nationally, although many more thought that it was now being overtaken by other schools. There was a strong intention to teach students more than knowledge, in particular skills, and to some extent attitudes, although staff seemed less confident with the concept of attitudes. Skills that were particularly emphasised were those to do with learning. Staff claimed to value a student centred approach. However, it was a broad consensus of opinion that the intentions were stronger than the reality, and that the students' experience of medical education would be on the whole a traditional one.

The main thrust of the curriculum and its assessment still appeared to be the acquisition and testing of factual knowledge. Methods of teaching and learning still emphasised the lecture

and work on the wards. Small group work in the first two years was rare, due to lack of staffing, and in the clinical years the size of groups was increasing, which staff said was detrimental to student interaction and student centredness. Considerable time had been allocated for students to engage in self directed learning, but it did not appear that much work had been put into thinking through what students should do in this time. Clinical staff reported that students arrived in their third year without the skills of self learning and expecting to be 'spoon fed'. Assessment was still dominated by the formal examination, the multiple choice questionnaire and the confrontational long case viva. It was generally felt that the University did not do enough to support teaching, valued research much more highly, and relied too much on outside funding to provide basic teaching.

There were however several positive elements. Student opinions about their course appeared to be actively sought, taken very seriously, and used to effect real changes. Essays were used as part of the continuous assessment, and constituted between 20% and 40% of the marks for various years. Some specialties, most notably Primary Medical Care, Palliative Care and Child Health had put considerable effort into the development of their teaching programmes. Public Health Medicine and the psycho-social sciences issues were included in all the assessed elements of the course, including staff from these disciplines taking part in the vivas for the formal examinations. A medical education development unit had been set up, and was providing much appreciated support for staff development.

CHAPTER SIX

DISCUSSION

AIMS

Overall aims of the thesis

One of the aims of this thesis is to contribute to theoretical understanding:

- ***The main aim of this thesis is to explore the relationship of the two worlds of health promotion and medical education. This thesis will attempt to look at where the goals, content and processes of medical education overlap with those of health promotion, and where they diverge, in order to discover whether it is possible to bring them together into a more effective relationship.***

So this discussion will attempt to outline some areas of interest to the theory of health promotion and medical education.

A secondary aim of this thesis is to be of some fairly immediate use to those who would engage in the practical task of developing health promotion in medical education:

- ***A secondary aim of this thesis is to suggest some strategies and priorities for action in developing health promotion in medical education.***

So this discussion will also suggest some practical applications of the findings.

Starting with the aims of the medical curriculum

- ***This thesis will attempt to discover what medical staff were trying to achieve in their teaching, as the starting point for uncovering the links and overlaps in the relationship between the medical curriculum and health promotion.***

The enquiry began by looking at the aims of the medical curriculum, as written in the medical curriculum book, and as stated in interview. This approach proved in practice to be a useful starting point for this study. It provided an overview of the medical curriculum that appeared to be meaningful to staff, and revealed many areas of overlap with the interests of health promotion. Particularly significant was the cluster of aims, mentioned second most frequently, concerned with *'psycho-social issues, patient centredness and Public Health Medicine approach'*. This cluster included prevention, holism, patient centredness, and

communication, all of them central to health promotion. There was also a strong intention to teach about health in the sense of normality.

Statements of aims also proved to be useful starting points when attempting to assess the importance of specific issues to medical staff, and were included in the various analyses of the issues of concern to health promotion.

Many of the attitudes that staff said they were hoping to transmit, such as patient centredness, teamwork, multi-professionalism and a critical perspective are also of central relevance to health promotion.

There was then from the outset many areas of natural and unforced overlap between some of the most important goals of those who taught the medical curriculum and the interests of health promotion. The method of attempting to start where staff are, by looking positively at what medical education is aiming at, rather than dwelling on what it was not, could form the basis of mutual understanding between the two worlds of medical education and health promotion. It is one that could be used with advantage by others attempting to develop health promotion in medical education.

HEALTH

The unimportance of positive health in the medical curriculum

- ***This thesis will examine the extent and nature of teaching about health, as opposed to illness and disease, in the medical curriculum, and staff attitudes towards the idea of health.***

'Health' was a term that was clearly familiar to most staff, and was used by most of them freely. It appeared from the written aims of the medical curriculum that the curriculum as a whole, and particularly the basic science courses, strongly intended to teach students about health and normality as well as disease and illness, and there were a few examples of teaching about normality in both the preclinical and clinical courses. Examples of teaching about positive health were to be found particularly in the psycho-social sciences, which contained several lectures on various aspects of the social and psychological nature of health, while Public Health Medicine taught a little on health promotion and measures of positive health. A few clinical coordinators said they would like the basic sciences to emphasise the normal more, to provide an essential touchstone against which to measure the abnormal. A few staff expressly regretted the tendency of medicine to focus on disease and illness.

So there were several positive indications of an interest in health, particularly the written intentions to teach about it, which are foundations on which any attempt to focus medical education more squarely on health could build.

However, analysis of the interviews suggested that the intentions to teach about health were not often realised in practice, and on the whole the overwhelming emphasis of the curriculum, in terms of time and priority, was on teaching about illness and disease. The belief of many commentators that medicine and medical education are essentially about illness and disease (Berliner and Salmon, 1980; McKee, 1988; Lupton, 1994; Catford and Nutbeam, 1984; Seedhouse, 1986; Green and Kreuter, 1991), and do not concern themselves much with normality, let alone with the more salutogenic models of wellness that many in health promotion find essential to their concerns (Antonovsky, 1979, 1987; Downie, Fyfe and Tannahill, 1990, Cribb and Dines, 1993; Tones and Tilford, 1994) would appear to be largely justified, in this instance at least.

Several suggestions were made by staff in interviews about why there should be such an emphasis on disease and illness in the medical curriculum. The educational backgrounds of the teaching staff, and the wish of the medical school to blur the distinction between preclinical and clinical studies were two reasons suggested. Most emphasis was placed on the motivations of the students, who were reported as tending to turn off discussions of health, dismissing such things as obvious and taken for granted, while seeing illness and disease as difficult, specialist, high status areas of knowledge, the mastery of which would set them apart from the commonsense world of the layman, and give them elite professional status.

The tendency for status and relevance to be associated with the study of illness, appeared to lead even staff from Public Health Medicine, who were keen to have more of both, to see problematising health as too foreign and esoteric for students to master, and thus to focus on illness and disease too in their search for credibility. They appeared to be much more interested in teaching about the epidemiology of disease, and about the critical appraisal of medical interventions, than they were in teaching about health.

In developing health promotion in medical education it would appear important to recognise that developing a focus on positive health, as suggested in the HEA's core curriculum document (Pringle, Fragstein and Craig, 1997) will be difficult, as it appears to run counter to the basic culture of medicine and the mind set of undergraduate medical students. In the short and medium term, developing work on health promotion solely from a basis in health would appear be very restrictive, and risk its marginalisation.

However, it would also seem important, in the longer term, not to lose sight of attempting to

develop more positive models of health. Clinical disciplines, although not at present apparently as likely to teach about health as the basic sciences and the psycho-social sciences, would appear to provide a crucial starting point, given their higher status in the eyes of students. In the Medical School in question, the Child Health attachment, which was categorised in the methodology chapter as higher status and was apparently highly regarded by students, was in fact the most strongly oriented towards health and normality of all the courses and attachments. This suggests that a reorientation of clinical medicine to include consideration of health and normality is possible. Staff from a few other clinical attachments, most notably Obstetrics and Gynaecology and Geriatric Medicine, also seemed to show sparks of interest in the normal and in positive health, on which further work might be developed. Other medical schools may contain similarly promising seedbeds for such a reorientation.

'Relative health'

We have said that, in the medium term at least, it may not be wise to attempt to develop health promotion solely from the basis of work on positive health. This may at first sight seem nonsensical. However, a concept which we have termed 'relative health' could prove to be more useful.

Although there was not much interest in positive health, a concept that could be termed 'relative health' was made explicit in three clinical attachments. The coordinators of the Primary Medical Care, Geriatric Medicine and Palliative Care attachments reported that they encouraged students to realise that it is possible for patients to be in some sense 'well', especially psychologically, despite their disease, and see that the task of the doctor is to help patients be as well as possible. Furthermore most of the clinical staff claimed to have a central concern with the idea of holism, or seeing the patient as a whole person, with a rich social and psychological life that might have caused the illness, and certainly mediated it in some way, and thus needed to be taken into account in all medical encounters. Holism could be therefore be seen as having the goal of helping the patient to achieve a better quality of life in the circumstances in which they found themselves, and it could therefore be said that many of the clinical courses worked implicitly with the concept of 'relative health'.

The concept of 'relative health' would appear to fit comfortably within one of the most widely accepted definitions of health, which is that health is a resource, not an absolute state (WHO, 1986b). If we take the concept of health as a resource seriously, then it is possible to say that promoting health becomes not about enabling people to be perfectly well, whatever that unattainable state means, but to be well enough to do what they want to do. Being well enough may then be very different for those with the ambition to climb Mount Everest, to those who wish to perfect their piano playing, or talk more to their

grandchildren. It allows people with disabilities to be nevertheless healthy. Being healthy may also involve recognising limitations, and building aspirations around them, discovering what you can do rather than dwelling on chasing a 'mirage' of perfect health (Dubos, 1979).

On the whole however, to the author's knowledge, few in health promotion have taken this insight to its logical conclusion, which is that, if we see health and illness as a continuum or spectrum (Downie, 1990; Aggleton, 1990; Cribb and Dines, 1993), and if we see health as a resource (WHO, 1986b), or as a foundation for living (Seedhouse, 1986), then the distinction between health and illness becomes interestingly blurred. It follows that there is no need to make the strong distinction between the concerns of medicine, which tend to be with illness and disease, and the concerns of health promotion, which tend to be with wellness. Indeed we may conclude that these dividing lines are unreal and unhelpful.

The concept of 'relative health' then becomes a key area of overlap between medicine and health promotion, and one within which a dialogue between the two worlds could usefully be developed.

Medicine as part of the health promotion process

Given the previous argument about the importance of the concept of 'relative health' there would appear to be no reason why medicine should not be accorded a clear place within health promotion, as an integral part of the health promotion process, and as one of the contexts in which health promotion can take place, whatever the health status of the participants.

Although most theoreticians in health promotion leave out curative medicine from their typologies, a few have suggested that it is possible to fit it within health promotion, as does French (1990) when he includes disease management in his typology. Tones points out, if we define health promotion as '*any measure which promotes health or prevents disease*', that it follows that logically we should include curative medicine:

> *While the classic WHO formulation points out that health is not merely the absence of disease, presumably it could be conceded that the cure of established disease will undoubtedly enhance health status. In which case, in the interest of logic and perhaps as a charitable gesture, medical treatment ought to be accorded a place somewhere in the model of health promotion.*
>
> Tones, 1986, p11.

It would seem sensible not to restrict our view of health promotion in medical education only to where health is being discussed, but to look also at where some of the models and principles of health promotion are being, and could be, applied in the context of illness too. The question as to whether medicine is health promoting can then move on from the sterile question of health or illness, to the much more interesting matters of the concepts and

principles employed within the activity, and the nature and quality of the relationship of the participants in the process.

If we take this perspective, then the roles played by doctors in their everyday tasks can potentially be health promoting. Curing disease is obviously a candidate, and medical interventions could, and should, be seen as an essential part of the ongoing process of health promotion, by moving people along the spectrum from illness to health. For health promotion to ignore or minimise the importance of the core curative function of medicine, and its clear place in the overall process of health promotion, is to be at best churlish, and at worst blindly parochial.

However, even mere symptom or pain control, is potentially a health promoting activity. It is well known that the triggers that cause patients to consult the doctor are highly subjective and contextualised (Mechanic, 1968; Richman, 1987; Armstrong, 1987). People often consult, not because their illness concerns them in any absolute sense, but because their symptoms are interfering with what they want to do. The level of physical or mental discomfort that people are prepared to tolerate before defining themselves as ill, and certainly before seeing a doctor, will vary greatly according to their own goals and priorities (Helman, 1990). So, helping people manage their symptoms in order to get on with their lives should be very much seen as a health promoting activity.

Similarly, if health is about recognising limitations, and building aspirations around them, it may be that the role of the doctor in helping patients realistically to come to terms with the restrictions that illness and disability impose, and to see the possibilities for achievement and satisfaction that lie within their capabilities, should also be seen as part of the doctor's role in health promotion.

It would seem that those who would develop health promotion in medical education need to stop berating doctors for being interested in illness. They need to take more seriously their own assertions (Aggleton, 1990; Dines and Cribb, 1993) that health and illness are not separate and antagonistic, but exist on a continuum or spectrum. The role of health promotion in the context of illness is beginning to be recognised, for example with the publication a major recent WHO reader on the subject (Kaplun, 1992), but it needs to be much more widely appreciated. The same complex, subtle and fascinating issues that arise in the context of health (Seedhouse, 1986; WHO, 1986a) arise in the context of illness too (GMC 1987b, 1993; White, 1988; McWhinney, 1989). Illness contains the same gradations and complexities (Stainton Rogers, 1991), the same elements of subjectivity (Lupton, 1994), the same key role for cultural determinants (Helman, 1990), the same interrelation of mind and body (Doswell, 1989), and gives rise to the same human and ethical challenges for those who would become professionally involved in it (Beauchamp and Childress, 1983). It

would perhaps be a useful beginning if psycho-social scientists and health promoters gave credit to those doctors who are extremely interested in these complex issues, and stopped using the alienating and divisive term *'medical model'* to label the view that illness is simple and obvious (Catford and Nutbeam, 1984; Green and Kreuter, 1991; Stacey, 1988). The disciplines of medicine and of health promotion pose many of the same challenges to those who practice them, and have in fact far more in common than many of their proponents on both sides appear to realise.

HEALTH PROMOTION

Concepts of health promotion held by medical staff

- ***This thesis will look at where health promotion and/or health education were taught under those names in the medical curriculum, what was included under those titles, what staff understood by the terms, and what attitudes they had towards them.***

- ***This thesis will in general include the term health education within health promotion, but it will investigate whether staff distinguished between the terms, and if so, what was the nature of the distinction they made.***

'Health promotion' and *'health education'*, under those specific names, did not make much of an appearance in the documentation of the medical curriculum: they were not cited as aims in the medical curriculum booklet, unlike most of the other issues looked at in this thesis. Only two staff, both from Public Health Medicine, cited them in their oral statement of aims. The terms were used quite frequently in interviews, by just under half the staff, but it should be born in mind that the interview questions explicitly asked about them: it seems unlikely, had this not been the case, that many staff would have talked about them spontaneously in relation to their courses. Staff talk about these issues, under their own names, was very brief, even in comparison with the amount of time staff spent discussing prevention, let alone in comparison with the lengthy and enthusiastic manner in which they discussed issues such as holism or patient centredness. So it would appear that the terms *'health promotion'* and *'health education'* were familiar to medical staff, but not particularly close to their hearts.

The debates that raged within health promotion and health education about the difference between the two terms, discussed in the rationale chapter, appeared to have had very little impact on medical staff: most of those who commented on the matter saw health promotion and health education as the same, and used the words synonymously, employed them loosely, and interchangeably with a range of others, most commonly with prevention and

giving lifestyle advice. It would appear then that the suggestion that medical students should be taught to '*understand the distinction between health education and health promotion*' made in the HEA's statement of a core curriculum for health promotion in medical education (Pringle, Fragstein and Craig, 1997, p. 6) would not be likely to give rise to work that would arouse much interest, and might risk being seen by medical students as another foreign issue.

On the whole, medical staff did not have very positive attitudes towards what they saw as health promotion. Few thought that health promotion was important, effective, or formed a strong part of the role of the doctor. This negative attitude was very prevalent, even in Primary Medical Care staff, where it seemed to have been formed in response to the interventionist health promotion role thrust upon GPs by Government, for which they felt the evidence was not there, and which they resented, coming as it did on top of the other work pressures they were under. Their negative attitudes about health promotion were very much in line with previous findings about GPs' concerns about its effectiveness (Robertson, 1992; Gibbens *et al*, 1993; Meldrum, 1991; Thomas, 1993; Oxcheck Study Group, 1994; Family Heart Study Group, 1994) and its impact on their already heavy workload (Hannay, 1993; Rose, 1993; Kaufman, 1990).

Resolving the perceived conflict between patient centredness and health promotion

The rationale chapter argued that respecting the human dignity of the patient and respecting their right to autonomy through the principle of voluntarism are fundamental principles on which an ethically sound approach to health promotion should be based. This issue is strongly connected with a debate which runs through health promotion, about whether the activity should be top down, imposed from above, or bottom up, arising from the concerns and interests of those whom it is designed to benefit (Beattie 1991). Most of the most widely respected and accepted models of health promotion advocate a bottom up approach as not only the most ethically sound, but also the most likely to be effective in terms of giving people the sense of ownership necessary to induce them to take action.

So it is ironic, given that those in health promotion tend to criticise doctors for being top down, professional-centred and authoritarian, that this was the view that some staff, especially those from Primary Medical Care and Geriatric Medicine tended to have of health promotion, and which they saw as incompatible with the bottom up, patient centred approach they wished to take.

This paradox has been uncovered by the author before in a previous round of interviews (Weare, 1986, 1988a) and is embedded in various broader pieces of work on GPs attitudes to prevention (Hannay, 1993; Rose, 1993) but appears to be little recognised in health promotion, where there has been little research on it. It was uncovered by research carried

out for an MA dissertation (Redfern, 1994) when 8 professors of General Practice interviewed all shared a concern that health promotion itself must not be top down and authoritarian if is to be compatible with the patient centred approach they all favoured. The researcher, who had lately come to health promotion after a career in General Practice wrote of his frustration at the lack of appreciation by those in health promotion of the patient centred approach in medicine, and his resentment that an authoritarian model should so often be labelled by health promotion as the 'medical model':

> *It is the author's experience, since leaving clinical practice, that the concept of the 'medical model' is often assumed to apply to most doctors. The fact that the authoritarian approach to health promotion has been labelled 'medical' rather than 'traditional' (education also has an authoritarian tradition) may be a sign of labelling, indicating a form of institutionalised prejudice'.*
>
> Redfern (1994) p. 22

Some recent typologies have indeed relabelled this approach, for example as *'traditional/ functionalist'* (Caplan, 1997).

It would seem important for those in health promotion to emphasise the use of a bottom up, patient centred approach when talking about their subject and its relevance to doctors, and to take pains to emphasise the centrality of this approach in the most widely favoured models of health promotion (Doxiadis, 1990; Tones and Tilford, 1994)

However, the negative views held by some doctors could, again paradoxically, provide a useful way in to clarify with those in medicine that their concerns about top down, imposed interventions are shared by many in health promotion (Nutbeam, 1986; Bunton and Macdonald, 1992; Cribb and Dines, 1993; Naidoo and Wills, 1994) and make clear to such doctors that there are approaches to health promotion, prevention and lifestyle advice, that are bottom up, patient centred and empowering.

Finding other words for health promotion

It is clear that the words *'health promotion'* and *'health education'* themselves do not appear to be helpful ones to use in the context of medicine. It would appear that the complex, positive, and social concepts that the words tend to imply for health promotion specialists are not those that are conjured up by the use of these words with medical staff, who tend to see health promotion as meaning *'prevention'*, and more specifically the *'giving of lifestyle advice'* to individuals. We have seen that for the medical staff who are in fact most likely to carry out the kind of holistic, patient centred practice that many in health promotion favour, most especially those in Primary Care, the words are likely to evoke an image of a top down, imposed, and authoritarian intervention, and therefore risk alienating the very people who should be most in favour of the underlying principles of health promotion.

Those who would develop health promotion in medical education need to be aware of the restrictive and rather unfortunate meaning that the term currently tends to have for doctors. They then have the option of attempting to challenge and change doctors' definitions of the words or, if they wish to tap into dimensions such as empowerment or social change, to use alternative and more specific terms which are more likely to have those connotations for doctors, and explain their terminology very carefully.

Teaching about behaviour and behaviour change

- ***This thesis will examine the extent and nature of teaching about health related behaviour, behaviour change, and behaviourism in the medical curriculum.***

A few people, mostly from the psycho-social sciences, explicitly mentioned theories of behaviour change in their discussion of what they understood by health promotion. Behaviour and behaviour change were frequently mentioned by staff in their accounts of what was taught to students. Specifically, behaviour change appeared to be used by clinical staff as the acid test of the effectiveness of health promotion and/or preventive interventions.

So it would appear that most medical staff understood and valued behaviour change as an outcome that made sense to them: an interest in behaviour change approaches would therefore appear to constitute an important area of overlap between medicine and health promotion.

The stages of change theory (Prochaska and Di Clemente, 1984) was mentioned in the lecture on health promotion given by the specialist lecturer. It appeared from the remarks of one teacher of Primary Medical Care, that it had been picked up on by at least some medical students, as he reported that they used this model in their third year seminar presentations on health promotion. The stages of change model suggests that change is not a simple black and white business, but that people go through various stages in a cycle of change, including relapsing. The task of the professional is to help diagnose the stage the person is at and take appropriate action to motivate them to move on to the next stage, usually through the linked concept of motivational interviewing (Miller and Rollnick, 1991). It is an approach that is proving popular in Primary Care settings, where its specificity and precision perhaps appeals to doctors, who see themselves as needing to avoid wasting time with inappropriate interventions (HEA, 1991; Rollnick, Heather and Bell, 1992; Speller and Priest, 1992). It would appear to have the advantages of being both patient centred and having the kind of systematic approach that would appeal to the orderly, science based, medical mind. The fact that a group of medical students remembered and employed the stages of change model, of which they had only heard once, two years later, and the fact that their teacher

remembered that they did, suggests that this model is one that strikes medical students and doctors as particularly interesting and appropriate.

Teaching the limited usefulness of 'telling people what to do'

- ***This thesis will examine whether students were taught that there is more to health promotion than telling people what to do.***

It would appear that the central belief of health promoters that 'telling people what to do' is both ineffective (Gatherer et al, 1979; Liedekerken, 1990; Veen, 1995) and unethical (Tones and Tilford, 1994) was shared by some who taught the medical curriculum. Students were apparently being given this message, and even some practice in alternative approaches, from several quarters, most notably from Psychology, Sociology, Public Health Medicine and one clinical specialty, Primary Medical Care. This is in line with findings from previous research, that suggest that some in medicine are aware of this dilemma (Sankar, 1986; Demak and Becker, 1987; Burnard, 1989).

On the whole messages about the need for wider approaches than 'telling people what to do' came from the lower status specialties and subjects. This is again in line with previous findings (Pendleton *et al*, 1984; McWhinney, 1985; Schofield and Arntson, 1989). Staff from these lower status area thought that 'telling people what to do' was an approach that could still be found within much of clinical medicine, particularly in the teaching of higher status specialties, such as Surgery and Medicine.

Convincing all clinicians of the need to do more than 'tell people what to do' would appear to be an issue which those who would develop health promotion in medicine need to tackle. They could take heart that there are some in medical schools, including Primary Medical Care specialists who could support this insight. There is some sophisticated work that has been developed in the context of Primary Care at a national level (HEA, 1991), and a priority would appear to be to broaden this approach to include hospital based specialties.

PREVENTION

- ***This thesis will examine the extent and nature of teaching about prevention, in the medical curriculum, and attitudes towards this issue.***

Concepts of prevention held by medical staff

Prevention was a familiar concept to the medical teachers, and one about which they appeared to feel fairly positive. As we have seen, most staff who used the term and/or

commented on health promotion, saw it as synonymous with prevention, a finding that is in line with previous studies of doctors in general (Collins, 1984; Orleans *et al*, 1985; Simons-Morton and Simons-Morton, 1987; Nussel, 1990; Redfern, 1994) and those who work in medical education in particular (Weare, 1986, 1988a; Crimlisk, 1990; Sharp, 1990; Wallace *et al*, 1990). Prevention was said to be taught in over half of the elements of the medical curriculum. In this Medical School it appeared that, to some extent, staff had started to take its presence for granted, judging by the very common 'double take' reaction many of them had in interview, where they first denied that prevention was taught, then immediately nominated several instances of its presence in their attachment.

Giving lifestyle advice was, as we have seen, strongly associated with prevention and both were commonly used to define health promotion. The subject of giving lifestyle advice was widely touched on across the curriculum, including the vital clinical part. It was mentioned in relation to many of the clinical attachments, especially the Primary Medical Care attachment, and was also taught in Child Health, Psychiatry and Medicine. Judging by the comments of the overall coordinator of the medical curriculum, who thought that secondary prevention would be routinely covered in all the fifth year attachments, it is possible that, like prevention, giving lifestyle advice was in fact even more prevalent than it appeared, as staff may have simply taken its presence for granted.

The centrality of prevention for medical education

On the whole, most staff who commented on the matter seemed positive, or at least not hostile, towards prevention and giving lifestyle advice. Some, and particularly the overall coordinators who had considerable power and influence, talked at length of the need for medicine and medical education to take these issues more seriously. This is a very positive finding, from which those who would develop health promotion in medicine can take heart and on which they can base developments. Given the tendency to push preventive approaches as an appropriate goal for medicine in general (DoH, 1992) and the popularity of prevention among patients (Wallace and Haines, 1984; Sullivan, 1988; Hughes, 1988), an interest in prevention would appear to provide one of the most solid foundations on which health promotion can build. It would seem that health promotion in medical education also needs to take prevention and giving lifestyle advice seriously as goals, as they appeared to be such salient concepts to many medical staff.

However a few staff expressed doubts about the effectiveness of prevention and/or health promotion and/or giving lifestyle advice. These concerns need to be addressed, and care taken not to make claims for health promotion and/or prevention that cannot be substantiated. There is a strong need to uncover what evidence there is for the effectiveness of preventive actions, and lifestyle advice, and to give this evidence high profile in discussion with doctors and medical students, using the kind of positivist approaches to

which they are likely to most easily relate.

Teaching about epidemiology and risk

- ***This thesis will examine the extent and nature of teaching of epidemiology in the medical curriculum, and at attitudes towards this issue.***

Epidemiology was taught in the majority of the basic science courses, mainly by the Public Health Medicine group. In the clinical years it was specifically mentioned in relation to the two Psychiatry attachments. Risk was taught in the basic sciences, again mostly by the Public Health Medicine group, and by a few of the clinical attachments, albeit opportunistically and in passing. So it would appear that there was some interest in epidemiology and risk in the medical curriculum, with a whole department seeing it as their main interest.

The rationale chapter suggested that the study of epidemiology, and the associated concept idea of risk, were thought to form essential tools for the understanding of more population based, social approaches to health promotion, especially those that were associated with prevention. They have been suggested as core topics for health promotion in the recent HEA policy document (Pringle, Fragstein and Craig, 1997). They have also been put forward as key issues that '*the independent practitioner*' ought to grasp in the GMC policy document, '*Tomorrow's Doctors*' (GMC, 1993). It would appear then that epidemiology and risk do indeed form important areas of overlap between health promotion and medical education.

However there was again a tendency to ghetto-ise these issues into the basic sciences, which constitute the parts of the curriculum that reportedly tend to be marginalised by medical staff and students. So it would seem important to attempt to develop teaching about epidemiology and risk in a clinical context too. The fact that a few clinical specialties paid some attention to the idea of risk, while Psychiatry appeared to treat epidemiology fairly seriously, gives some indication that this might be possible.

PSYCHO-SOCIAL ISSUES AND PERSPECTIVES

- ***This thesis will examine the extent and nature of teaching about psycho-social aspects of health, illness and disease in the medical curriculum, and staff attitudes towards this issue.***

The central role of Sociology and Psychology for health promotion

A broad range of social and psychological issues of central relevance to health promotion

were covered in the teaching of the Psychology and Sociology courses that ran through the first two years. All of the issues mentioned as central to health promotion in the rationale chapter appeared to be touched on (with the exception of radical social change), although it should be recalled that the total time available for the coverage of such issues was only about 48 hours across the two years. So, the two disciplines of Psychology and Sociology are clearly of key importance for the transmission of health promotion.

In this research, staff from the psycho-social tended to have more complex, positive, and social definitions of the terms *'health promotion'* and *'health education'*, be more likely to be aware of the difference between them, and be more likely to link them explicitly with theories of behaviour change and social action than clinical medical staff. In developing health promotion, such psycho-social scientists could be both encouraged to see the links between health promotion and their own specialist work, and used to disseminate the wider, more positive and more socially oriented models of health promotion that health promoters tend to favour.

Although most agree that health promotion should not be restricted to particular subjects, it is clear then the psycho-social sciences have a particularly central place in the transmission of health promotion in the medical curriculum (GMC, 1987b). Their fate is therefore of central interest to health promotion, which needs to contribute to efforts to support them in their quest for status and recognition in the Medical School, and help them find an appropriate role and place in the medical curriculum.

The problematic status of the psycho-social sciences

It was clear that a major barrier to the teaching of psycho-social perspectives in this Medical School was the perception of all who commented on the matter, that the psycho-social sciences constituted a significant problem. The medical students did not apparently like the teaching of psycho-social science, especially Sociology, and tended to vote with their feet, to disrupt lectures, and to give the subjects very grades in their course feedback. Students were also said to be anxious about their assessments in the higher status areas of the biological sciences, and as a result concentrate on them and the learning facts approach they were said to encourage, to the detriment of their learning the more reflective ways of thinking of the psycho-social sciences. Several staff felt that these attitudes were partly derived from other medical staff, who demonstrated hostility towards the psycho-social sciences. The psycho-social scientists, and those medical staff who supported them, saw psycho-social science as marginalised by the mainstream curriculum and mainstream clinical teachers.

Such few studies as exist on the teaching of the psycho-social sciences and Public Health Medicine in medical education have indeed shown it to be highly problematic in all medical

schools (Ewan, 1987, 1988). In 1987, the GMC special report on what it called '*The Teaching of the Behavioural Sciences and Community Medicine*' noted what it termed '*a discrepancy between the potential of the behavioural sciences (and) community medicine to contribute to medical education and the contribution currently made*' (GMC, 1987b, p.3), and suggested that their investigations had found a tendency for them to *'be regarded as optional extras'*. They noted that these areas '*appeared to have low status in most medical schools*', a problem they attributed to *'dismissive attitudes'* in clinical and preclinical colleagues, which tended to rub off on students. Further barriers were said to include inadequate procedures for assessment, and lack of staff and financial resourcing (*ibid,* p. 4), the last of which tended to mean that students were taught in unsatisfactorily large groups. The GMC particularly felt that the tendency to classify these subjects as 'preclinical sciences' meant that medical students could not perceive their relationship to patient care, and thus tended to dismiss them as irrelevant. It would appear, from this research, that nothing at all has changed in terms of the status of the psycho-social sciences in medical education, at this medical school at least.

Psycho-social science constitutes a different epistemology from medicine

Several staff described the problem as a clash of cultures or epistemologies, in which the psycho-social sciences, and particularly Sociology, were conceptualised as interpretive, reflective and abstract, in contrast to medicine which was conceptualised as positivist, concrete and facts based. It was felt that the teaching methods used by staff from the two areas reflected this difference, with medicine seen as using a didactic approach to 'teach lots of facts about things', while the psycho-social sciences invited the students to reflect on complex arguments in which many points of view were contrasted. Psycho-social science also tended to be seen as everyday commonsense and thus rejected by students, and some staff, as unworthy of serious effort and consideration.

Psychology more accepted than Sociology

All who spoke on the subject agreed that, in so far as students themselves distinguished them, Psychology was better thought of by students than was Sociology. The individualistic focus of Psychology was thought to be easier to assimilate into the medical perspective than the social, collectivist focus of Sociology, a finding which is very much in line with previous work in this area (Colditz, 1983). Sociology was also particularly likely to be branded with the stereotype of being abstract, reflective, irrelevant, common sense.

In 1987, the GMC's (1987b) detailed investigation into the teaching of these areas in medical schools noted that Psychology tended on average to have twice the time given to it compared with Sociology. It found that *'the relevance of the discipline of medical Sociology to clinical medicine is not so self evident'*, that Deans tended to assume that social issues were adequately covered by other subjects, such as community medicine, and that

Sociologists had sometimes been accused, and with some justification, of being too negative about the medical profession (*ibid,* p.10). It noted that Sociology was particularly likely to be seen as irrelevant as, unlike Psychology, it lacked any clinical applications, and recommended that particular effort be made to make links between Sociology and other parts of the curriculum. So, again, nothing appears to have changed.

The implications of this marginalisation of Sociology for social approaches to health promotion will be looked at in its own right a little later in this chapter.

Caution in using the term *'psycho-social'*

The term *'psycho-social'* was not much used in the clinical years, where the term *'holism'* was preferred, which seemed to carry a more applied and patient centred meaning. It would seem then that the term *'psycho-social'* should be used with caution by those who would develop health promotion in medicine, as it tends to be connected with areas of the curriculum that do not have a high status, and which students are said to enjoy leaving behind when they enter the clinical years. It is likely that if health promotion, and indeed perhaps the psycho-social sciences in general used alternative terms, in particular *'holism'*, this would help a wide range of medical staff, and medical students, to see the relevance of such perspectives in the all important clinical context.

Short term: the need to use epistemologies that are familiar to medicine

It would appear that some of the psycho-social concepts and approaches that health promotion holds most dear, particularly those connected with the taking of a social perspective on health, are currently held in low esteem within medical education. The interpretive, reflective methodologies, on which much work in health promotion draws, tend to be marginalised by the positivist approach of mainstream medicine, as has been reported previously (Dingwall, 1992; Silverman, 1992.) Those attempting to develop health promotion in medical education should be at least aware that employing social and reflective styles of discourse is likely to alienate many medical students (Colditz, 1983). They might choose not to use them if time is short, and/or to use more individualist, positivist approaches as a way of leading into them. At the very least they should use them cautiously and wittingly, being aware of the divide between this style of teaching and that to which the students are used, and explaining the justification for using the approach to the students.

Longer term: the need to broaden the range of epistemologies used in medicine

It is clear that medicine and medical education currently tend to have a very limited view of what constitutes valid paradigms of knowledge and research. However that this is gradually changing. As medicine becomes involved in the study of more complex, subjective and cultural aspects of health and illness, it is coming to appreciate that a wider repertoire is

needed than just the empirical, positivist paradigm. The increased emphasis in medicine and medical education on such softer issues as patient centredness, holism, subjectivity, and mental health has lead to a shift to more inclusive and more flexible ways of thinking, as medicine has gradually come to recognise that such approaches involve different ways of thinking to the traditional scientific paradigm. In attempting to understand the social context in which health related behaviour takes place, to examine the personal and cultural meanings, motives and beliefs of those who are studied, and to assess changes in attitudes and beliefs, qualitative research paradigms and perspectives, such as gestalt, interactionism, ethnography and phenomenology are indicated (Dingwall, 1992; Silverman, 1992). Primary Medical Care, has long had a tradition of interest in softer approaches to research (for example the work of the Balints between the 1950s (Balint 1957) and the 1990s (Balint *et al*, 1993). There are some indications that medicine in general is starting to take an interest in qualitative as well as quantitative approaches, as evidenced, for example by a series of fairly recent articles in British Medical Journal (Pope and Mays, 1995).

So in the longer term, health promotion can take advantage of, support and be part of, the gradual softening and broadening that is coming into medical thinking, and help build a context in which a wide range of epistemologies are available for those who would study health and disease. In this, more flexible and inclusive landscape, dialogue between health promotion and medicine will then automatically become a great deal easier.

Involve staff who teach psycho-social issues and health promotion in the world of the medical school

In the Medical School in question there was an overwhelming perception among the medical staff that medical education would be better served if the psycho-social staff who taught medical students were specialists in the health field, familiar with a health context and used to working with concepts and problems that are demonstrably and perceptibly relevant to doctors. In order for this to happen, they felt that psycho-social staff needed to placed in their midst. The psycho-social scientists interviewed tended to reject both of these points of view, seeing themselves as already teaching aspects of relevance, and fearing that the location of psycho-social scientists in the medical school would risk them 'going native', being isolated and blighting career prospects.

However, the strength of feeling behind these calls for greater integration of psycho-social inputs to the curriculum need to be taken seriously. The GMC (1987b) emphasised the need for staff integration, either by specialist staff from the Psycho-social sciences joining the medical school itself or, where the small numbers involved risked their isolation, by restricting teaching to *'a designated and appropriate person'* who could forge strong and real links with the school. They suggested the strong integration of these subjects, with one another and with other subjects, especially the clinical specialties.

So it would seem that medical staff need to feel a greater sense of participation in, and some shared ownership of, psycho-social and health promotion if they to give it their support, otherwise, in the epistemological battle for the hearts and mind of medical students, mainstream medicine will always be the overall long term winner. It is arguably preferable to teach aspects of psycho-social science and health promotion that are less acceptable in the world of the subjects' specialists, being, for example, less theoretical and more applied than the specialists would ideally like, but to have them supported, integrated into clinical work and accepted by the students, than to attempt to transmit theoretically excellent work that is marginalised and denigrated, and turns many students off the subjects altogether. If undergraduate medical students were persuaded of the relevance of some fairly basic aspects of the psycho-social sciences and health promotion to their clinical work, there would seem to be a better chance that they would return to them later, when they could be helped to appreciate their deeper levels of subtlety.

Health promotion then has much to learn from the problems that psycho-social science is experiencing in the medical curriculum, problems which appear to be common across many medical schools, and problems which it indeed shares. Psycho-social scientists, including those involved in health promotion, need to be helped to be more familiar with the language and contexts of medicine, and to recognise, be comfortable and effective working with the styles and approaches within which doctors tend to operate, if they are gradually to induce medical students and medical staff to see the world from a broader point of view. The key element in building bridges between what are currently seen as two different worlds is the perceived relevance of what is taught to the everyday clinical practice of doctors. Health promotion must take care constantly to make its relevance to a clinical medical context clear, if it is not to be marginalised and discounted. It would seem sensible that staff who are designated to teach health promotion in medical education have a genuine understanding of, interest in, and positive attitudes toward, medicine, and are possibly located in the Medical School itself.

It would also seem sensible to be wary of placing all teaching about health promotion within the psycho-social sciences, tempting as they may appear as an appropriate and congenial home for many of the central ideas of health promotion. To do so is to risk the marginalisation of health promotion. Seeking a place in higher status, clinical attachments, not instead of, but as well, as in the psycho-social sciences, would seem more likely to ensure that health promotion is taken seriously by and, most importantly, applied in the subsequent practice of, medical students.

Attempts at integrating Public Health and the Psycho-social sciences together

This research showed that a recent effort that had been made to integrate the teaching of Psychology, Sociology and Public Health Medicine together in the medical curriculum was

generally thought to have failed quite badly. The reasons put forward were that the staff involved in the creation of the integrated course had bitten off more than they could chew, claiming more time for their subjects than they had staff or energy to fill, which created great resentment in other staff. This shortfall was thought to have been exacerbated by the staff who had set up the new course moving on and leaving other, less enthusiastic staff to inherit the relatively large commitment. Staff from the three contributing disciplines appeared to have now cut down their inputs, and each discipline was trying to establish their separate identity more clearly in the minds of medical students and the Medical School. In particular staff from Public Health Medicine appeared to feel that, although themselves sympathetic to the psycho-social sciences, they were aware that students were not, and thought they would do better to associate themselves more strongly with the clinical disciplines.

Learning for health promotion : make haste slowly

This experience of abortive integration forms a reminder that it is often naive to assume that a development is being proposed for the first time. Medical education is a graveyard of well meaning innovations, many of them connected with issues to do with health promotion, from the failure of which much can be learnt. It points to the need to be cautious in the amount of time demanded for health promotion: in a crowded curriculum it may be better to be seen to do a little well rather than overreach and fail, alienating those whose courses provide the surrounding context and who feel they could do with more time. It is also a reminder, once again, of the need to start where staff are, and build on existing structures and approaches rather than start with a clean sheet and develop courses from scratch with largely new teams. Such new teams may not fully understand the culture of the medical school within which they are working. Furthermore, any innovation is likely to be subject to the 'Hawthorne effect', going well in the early stages when the novelty makes staff enthusiastic, only to founder when staff become bored, disillusioned, or pass responsibility on to other staff who do not feel the same sense of ownership.

The experience also suggests that the integrated 'metamodels' that are currently in vogue in health promotion, such as Precede-Proceed (Green and Kreuter, 1991) and the Health Action Model (Tones, 1987a) may be the most intellectually sound and satisfying to specialists, but in some contexts, such as fragmented academia, they may well be difficult to realise in practice. The GMC noted that integration is '*costly in time and effort and therefore difficult to contemplate when resources are scarce*' (GMC, 1987b, p.8). To sustain integration involves addressing some of the complex interpersonal issues, such as professional boundaries and territorialism, that tend to sabotage it. In situations where integrated curricula are not well established it may be better to tie health promotion into discipline based approaches. This does not of course preclude those who wish to develop

health promotion in medical education joining attempts to establish a foundation of genuine disciplinary integration in the longer run, into which, once it is established, more integrated models of health promotion can then fit more comfortably.

SOCIAL PERSPECTIVES AND ISSUES

As social perspectives and issues are so central to health promotion, this section will look more deeply at the matter of how they were treated in the medical curriculum.

- ***This thesis will look at the extent and nature of teaching about the social issues in general, the taking of a population approach and the social determinants of health in the medical curriculum.***

The undervaluing of a broad social perspective and the concept of social change
Students were said to be taught some of the constituent features of taking a more broadly social and population based approach in the basic science years, when they were said to spend a great deal of time studying epidemiology, and Sociology itself. However, as we saw earlier, it appeared that many students had a strong antipathy to the teaching of Sociology in particular. There was no evidence that the clinical attachments taught students anything at all about looking at wider society, or at the community as a whole: it appeared that any such broad social perspectives were left behind, and with some relief by students perhaps, with the basic science years.

- ***This thesis will look at the extent and nature of teaching about the healthy public policy/ settings approach in the medical curriculum.***

Healthy public policies and healthy environments/ settings were apparently only touched on in one instance, in the specialist lecture on health promotion. There would appear to have been no teaching about the settings approach, not even healthy hospitals (Health Promotion Authority for Wales, 1989; Spiros and Sol, 1991; HEA, 1993), outside of this one lecture. So it would appear then that the settings approach that is now so central to health promotion (Dean and Hancock, 1992; Health Promotion International, 1991; Grossman and Scala, 1993) made little appearance in this medical curriculum.

However, some staff in Public Health Medicine claimed to see environmental approaches as important, and the group's teaching coordinator said they were planning to develop teaching on healthy public policies. It seems then that if work about such issues is to be developed, Public Health Medicine would appear to provide the most useful context for it.

- ***This thesis will look at the extent and nature of teaching about social change in the medical curriculum.***

There appeared to be no teaching about social change, or the politics of health, at all, even within the Sociology course. When questioned about it, the coordinator of Sociology indicated that he thought the likelihood of social change in society as a whole was so slight, that it was not worth teaching medical students about it. This medical school at least had not moved any closer to helping medical students understand the models of social change put forward for their consideration in no less an organ than the British Medical Journal by Draper *et al* nearly two decades ago (Draper *et al,* 1980).

All current typologies of health promotion include a concern with the broad social determinants of health, as essential features of health promotion (Downie, Fyfe and Tannahill, 1990; Cribb and Dines, 1993; Tones and Tilford, 1994). Many also feel that health promotion must concern itself with social change (Caplan, 1997; Doyal, 1983; Mitchell, 1984; Rodmell and Watt, 1986), while the social empowerment approach is, together with the complementary self empowerment approach, the dominant model in health promotion (WHO, 1986b, Tones and Tilford, 1994). However, at present, a concern with wider society, the broad social determinants of disease and illness, the settings approach, social change, and social empowerment would appear to be the issues on which health promotion and medical education are most widely divided. It would appear that Tudor Hart's (1988) insight, that doctors, with their positions of relative wealth and security, tend naturally towards conservatism and are not very interested in social issues, was reinforced in this case. It would seem most unlikely that the medical students taught by this medical school would be drawn to play roles as lobbyists, advocates or activists for health in the way suggested by some in health promotion (Campbell, 1984; Tones, 1987b; WHO, 1986b; Marshall, 1992; Stutor, 1993; Kemm and Close, 1995).

The suggestion made in the rationale chapter that broad social approaches appeared to be less congenial to medical staff, as medicine is traditionally focused on the individual rather than on the group, the community, or society as a whole, would appear then to be justified from this research. The assertion of the GMC (1987b) that *'nearly all illness stems, directly or indirectly, from the environment human beings create for themselves, in the form of the society in which they live,'* would seem not to be seriously reflected, in this medical curriculum at least.

Holism: a cause for greater optimism

The discussion so far may cause the reader to feel that teaching about the taking of a social perspective in medical education is a lost cause. However this research suggests that this in fact was far from being the case. Psycho-social approaches in general, and social

approaches in particular, were very much alive and well in this Medical School, but in a more applied and limited guise, and living under a different name, holism.

The term *'holism'* was used to mean looking at the patient as a whole, seeing them as more than their physical symptoms, taking into account aspects of their social condition, such as their job, where they lived, and their family circumstances, and recognising the importance for the doctor of aspects of the patient's psychology, such as their attitudes, motives, level of understanding, and present emotional state. Such a concept was used by the coordinators of the majority of the clinical elements of the course, and the terms *'holism'* and/or *'holistic'* were used by nearly half of all clinicians interviewed. It was thought by several staff to permeate all the clinical elements in the sense of being a part of taking a history, which was taught and practised constantly in all attachments, and which routinely included social and psychological issues. It appeared to be particularly central in the lower status attachments, such as Primary Medical Care and Palliative Care. However, one of the higher status specialties, Child Health, was centrally interested in holism, and even in Orthopaedics and Surgery, it was claimed that holism was emphasised, at least in the limited sense of encouraging students to enquire about the suitability of the home circumstances into which they were discharging the patient. It appeared that mainstream medicine took seriously the view of the GMC's document *'Tomorrow's Doctors'* (1993) that great emphasis should be placed on teaching students about the *social, cultural and environmental factors which contribute to health or illness* (GMC, 1993, p.25), in relation to individual patients.

So the suggestion of the rationale chapter that holism is beginning to have an strong impact on medicine (Tuckett *et al*, 1985; McWhinney, 1989) is supported from this research. Holism would appear to be a powerful and well accepted concept within medical education, making a strong appearance in the clinical context which is so appealing to medical students, even in the higher status specialties. Holism thus provides a very promising link between the worlds of medical education and social approaches, the psycho-social sciences and health promotion. The holistic perspective, individualised and specific as it may be, could provide a springboard for the development of more broadly social approaches.

The shift to the community: could it produce a reorientation to a social perspective?

- ***This thesis will examine whether there was a shift to teaching more about primary care and the community in the medical curriculum, and, if so, what staff thought about this development.***

This study produced very little evidence of teaching about the community, nor any evidence that any more of such teaching was planned. So the principles and practice of community empowerment that the rationale chapter suggested are so dear to those in health promotion

would appear at present to constitute a foreign concept within medical education.

There was also, at the time of the study, not much teaching in the community, in the sense of taking students out of the hospital setting. However the consensus was that a move away from the general hospital as the main base for medical education was imminent and likely to be far reaching. All agreed that the patterns of early discharge from hospital meant that students needed to spend more time in other contexts if they were to gain sufficient clinical experience. Several commented that this would be likely to lead to an increase in interest in issues such as prevention, holism and patient centredness, which were thought to be more present in primary care and in smaller, local hospitals than in the 'high tech' world of the centralised general hospital.

The shift away from the isolated world of the general hospital and into smaller district hospitals and primary care would appear to be about to provide a valuable opportunity for community aspects of medical education to be better developed. It may be an opportune moment for those who wish to develop broader social aspects of health promotion in medical education to capitalise on this shift and gear up to take advantage of it. It may be that, once medical education is more firmly in the community and within the ambit of Primary Medical Care, that teaching about the community, about the wider social determinants of health, and possibly even about community empowerment and the doctor's role in social change, will be easier to develop. However, realistically, it looks set to be a long haul.

PATIENT CENTREDNESS, COMMUNICATION AND SELF EMPOWERMENT

These two issues of patient centredness and communication proved to be strongly linked in the minds of staff. Furthermore, some of the work being carried out under these titles appeared to be, to all intents and purposes, self empowerment. So the three issues will be looked at together in this section.

- ***This thesis will examine the extent and nature of teaching about patient centredness in the medical curriculum and staff attitudes towards this issue.***

- ***This thesis will attempt to assess the extent and nature of teaching about communication in the medical curriculum, and staff attitudes towards this issue.***

- ***This thesis will examine the extent and nature of teaching about self empowerment approaches in the medical curriculum and staff attitudes towards this issue.***

Empowerment

Only three people, the specialist in health promotion, a coordinator of Psychology and a teacher from Primary Medical Care, used the precise term '*empowerment*' . So it would not appear to be a term that is very familiar to most medical staff.

It was significant however that the Primary Medical Care teacher juxtaposed the term *'empowerment'* with *'patient centredness'*. Although not themselves using the term '*empowerment*', the models of patient centredness and the models of communication that many of the other clinical staff used were, to all intents and purposes, empowering ones, as we shall see.

Patient centredness as central to the clinical medical curriculum

Patient centredness was mentioned in nearly all of the clinical elements of the course. Most of the clinical staff talked about it positively and at length. Like holism, patient centredness was said to be included in the routine matter of taking a history, in the sense of clinicians taking into account the patient's mood and psychological state when taking a history. Patient centredness was more strongly emphasised by staff from lower status specialties, being presented as absolutely central in Primary Medical Care, Geriatrics, and Palliative Care, although the higher status specialty of Child Health also saw it as key. This research did not then confirm the assertion of Metcalfe (1989), who suggested that patient centredness is entirely confined to Primary Medical Care, as at least lip service was paid to it in almost all of the clinical specialties.

Patient centredness was seen by the medical staff as having at least two elements that can be seen as essentially 'Rogerian', after the therapist, Carl Rogers (Rogers, 1959). The first is having empathy with patients, in terms of finding out about the individual patient's state of mind, motivations, beliefs, and personal needs. The second was that of the need for respect for the patient, in the sense of recognising their rights, dignity and autonomy.

This research would confirm then what the rationale chapter suggested, that health promotion has set up a straw man in its simplistic and inevitable identification of medicine with an authoritarian, doctor-centred model of the doctor-patient relationship. The interest shown in patient centredness is in line with the copious literature about patient centredness, empathy and respect in medicine in general (Tuckett *et al*, 1985; McWhinney, 1985; Levenstein *et al*, 1989; White, 1988; Brearly, 1990; Beauchamp and Childress, 1983; Gillion, 1990) and on teaching these attributes in medical education in particular (GMC, 1993; Davis and Nicholaou, 1992; Meakin and Lloyd, 1996). It would appear, as we have already suggested, that health promotion is to some extent pushing at an open door when it attempts to ask doctors to be more patient centred, and is in danger of failing to realise that

it is viewed by some in the medical profession as having the very top down attitude for which it criticises others.

So a strong concern with patient centredness would appear to offer a key area of overlap of interest and principle between medical education and self empowerment models of health promotion.

Empowerment approaches to communication in the medical curriculum

The rationale chapter argued that communication is central to effective health promotion. Empowerment models of health promotion rely on the professional having a skilled grasp on the complex communication skills involved in making clients more self aware, confident and autonomous (Anderson, 1988; Tones and Tilford, 1994) . There was evidence that some of the clinical specialties were teaching such empowering skills to medical students.

Primary Care were generally acknowledged to be leading the field in the Medical School in terms of communication skills teaching. They emphasised communication as a central goal, and taught it throughout their courses, especially through the OSCE, where students were taught and assessed through role play with feedback. The OSCE was employing what some have identified as the specific features that make some communication skills courses for medical students more effective than others, such as closely defining the skills (Pendleton and Hasler, 1983; Stewart and Roter, 1989) and practising them in very small groups, using videoed role plays with standardised patients and feedback (Caroll and Munroe, 1979; Bouhuijs, 1987; Schofield and Arntson, 1989). In keeping with their interest in patient centredness, the approach they took was very patient focused, using a checklist to grade the students that concentrated on the students' ability to listen to the patient, discover their state of mind, come to a shared formulation of the problem and negotiate future plans. The patients themselves acted as a major source of feedback for the student.

Several other clinical specialties, namely Palliative Care, Genito-Urinary Medicine, Child Health, Geriatrics, and Obstetrics and Gynaecology, also claimed to prioritise teaching a patient centred approach to communication. A common theme that ran through all of them was the importance of teaching the students that it was not the objective nature of the disease that should concern them, but what the disease meant to the patient.

The Palliative Care attachment prioritised teaching students to overcome their fears, and talk easily and comfortably with patients and their relatives about cancer: the attachment encouraged students to find out about what mattered to the patients by listening to their stories rather than to take a formal medical history. The Genito Urinary attachment was considered by its coordinator to be the only part of the course where the students could learn to *'talk about sex with patients without feeling embarrassment'*, and taught some of the

basic skills in taking a patient focused sexual history in a detailed and directed way. The third year Child Health attachment attempted get students to feel comfortable communicating with children, by encouraging them literally to get down on their hands and knees and see the world from a child's point of view.

So communication was being fairly extensively taught, and not just by Primary Care, but by some of the other clinical specialties, and where it was taught, an empowering, patient centred model was employed as a yardstick of effectiveness. It would appear that some of these staff were aware that effective communication, in the sense of really listening to patients and finding out what their needs are, is a difficult, complex, subtle business, that takes many years and much effort to learn to do effectively, and can be employed with various levels of skill.

So, despite the fact that medical staff may not use the actual term much, those interested in health promotion could take heart from the fact that some of the basic principles of self empowerment seem to have a place in medical education, and across a range of clinical specialties. There is some support too for an empowerment approach from those who shape medical education policy. Although not using that term, empowerment models could be seen as implied in the GMC's proposals for medical education contained in '*Tomorrow's Doctors*' (GMC, 1993, p.17), in its emphasis on the importance of teaching medical students the skills of *'counselling'*. The interest and skill in empowering, patient centred communication forms another, key, area of overlap of interest between medical education and health promotion.

The need to spread patient centredness, communication and empowerment to the rest of the medical curriculum

We should not however make the mistake of seeing patient centred communication as universally taught in the Medical School. Communication may have been mentioned in relation to half of the course elements, and the majority of the clinical elements, but it was the view of those clinical specialities who took the teaching of communication skills seriously, such as Primary Medical Care and Palliative Care, that some other clinicians saw communication as a low level skill. It certainly appeared from the interviews that, apart from Child Health, those in the higher status hospital based clinical specialties tended to see communication as a rather one dimensional, simple and obvious business that could be picked up fairly easily by students from witnessing the example of more or less any practising doctor. It is particularly of concern that Psychiatry had decided not to teach communication themselves, even though they appeared to value it, in order not to identify themselves with such 'soft' issues, and risk diminishing their traditionally shaky status (Bruhn and Parsons, 1964, 1965; Furnham, 1986; Creed and Goldberg, 1987; Soufi and Raoof, 1992) even further.

Furthermore, as we have seen, although most clinical specialities claimed to support holism and patient centredness, it was the opinion of the third year coordinator that, among most of the high status specialties such as Surgery or Medicine, the support they gave in practice to patient centredness would be fairly minimal, just a matter of lip service or, as she more memorably put it, *'forget it, dream on'*. It was certainly the case that, apart from the coordinator of Child Health, those from the higher status specialities talked about patient centredness much less, and with much less emphasis and enthusiasm, than the lower status ones.

So, there would appear to be some way to go before patient centred, empowering approaches to communication are generally accepted and supported right across the Medical School. However it is cheering to note that efforts to push this development along were coming from within the Medical School itself. Communication had been designated as a vertical thread, to be taught and monitored across all the specialities. Many staff, including the overall coordinator of the medical curriculum, were strongly of the opinion that it should be taught proactively in all specialties. Most optimistically of all, staff from Primary Care and Psychiatry had formulated a programme in teaching basic communication skills in clinical medicine in the Clinical Foundation Course, for which they had trained tutors from all the hospital specialities to work with students in small groups, giving feedback on videoed consultations. This approach was explicitly based on the highly patient and student centred activities, procedures and ethos of the Primary Medical Care OSCE.

So there was evidence that a patient centred, empowering approach to doctor patient communication was beginning to be spread out from the specialties that were traditionally associated with it, and be taught to, and thus by, staff from all the clinical specialties.

Linking medicine and health promotion through empowerment

Those who are involved in health promotion would do well to make the link with the work that is taking place right across medical schools on teaching communication skills, and developing patient centred approaches, and to engage in positive dialogue with those involved in this work.

In this effort, the concept of empowerment could act as a bridge between the two worlds of medical education and health promotion. Medical staff could be encouraged to connect the patient centred work in which they are engaged with the concept of empowerment, and through this link, to health promotion. Such conceptual development might help to resolve some of the contradictions some medical staff saw as inherent in the relationship of health promotion to patient centredness.

Taking empowerment further

It would seem that all clinical staff, even those in Primary Care, might have something to learn from health promotion about some of the proactive techniques that can be used to promote empowerment. As we have seen, medical staff were likely see patient centredness as being essentially concerned with respect for the patient's autonomy, and some, especially in Primary Care, Geriatric Medicine and Palliative Care, felt very passionate about this. They appeared however to see the patient's autonomy as absolute and pre-given, and the role of the doctor as a relatively passive one of discovering but not interfering with the patients' beliefs and understandings, or questioning their decisions. However, as the rationale chapter suggested, those who support empowerment from within health promotion are more likely to see it as achieved rather than pre-given, and health professionals as having a positive role in helping patients become more autonomous, through a range of vigourous educational techniques, such as values clarification, decision making, and the building of self esteem (Anderson, 1986, 1988; Woolfe and Fewell, 1991; Cherry *et al*, 1991; Tones, 1992). Such active approaches to the creation of autonomy were not discussed by any of the medical staff interviewed, but, given their interest in patient centredness, and their awareness of some of the conflicts and contradictions around the doctor patient relationship, a more detailed exploration of the issues connected with empowerment, and the techniques it uses might well be of interest to them.

The importance of mental health

A recurrent theme, apparent in all of the specialties that emphasised patient centredness, was their prioritisation of mental and emotional health over physical health.

Three of these specialties Geriatric Medicine, Palliative Care, and Psychiatry, made particular efforts to help students relate to patient whom they found difficult and/or with whom they did not find it easy to identify, and these efforts appear to have met with some success. The efforts of the Geriatric attachment reflect a widespread interest in medical education with teaching students to relate to the elderly, including the deaf and cognitively impaired (Thorson and Powell, 1991; Sainsbury, Wilkinson and Smith, 1992; Deary *et al*, 1993; GMC, 1993). Palliative Care teaching in the Medical School was particularly progressive, and was meeting the concern expressed in the literature about medical students' emotional difficulties with dealing with the dying (Hull, 1991; Field, 1984) with some very proactive, and apparently very popular, teaching about the emotional needs of both students, and of patients with cancer. Psychiatry was concerned to make students understand the 'stigma' of mental illness, and its potentially devastating consequences for the individual.

Interestingly, all of these 'challenging' patients raised mental and emotional rather than physical health issues. This links with the emphasis on patient centredness, which was seen by staff as implying that, where there was a conflict between the physical health status of

patients and their mental and emotional health (in terms of anxiety, personal beliefs, and happiness for example) that the mental health needs of patients should take precedence.

The particular interest shown in the Medical School in the mental and emotional health needs of patients, (and incidentally in the mental health needs of students, an issue to which we will turn later) is another important area of overlap on which health promotion in medical education could build. It is important for those who would develop health promotion in medical education to bear in mind that for most people, including some of the most progressive in the medical profession, the promotion of mental and emotional health is at least as important as the promotion of physical health. They therefore to emphasise the concerns of health promotion with mental and emotional well being, as well as with physical health. To do so might help reduce the image of health promotion in the minds of some doctors as authoritarian, top down, and healthist.

THE ROLE AND POWER OF MEDICINE

- ***This thesis will look at the extent and nature of teaching about the role and power of medicine, in relation to society, the other professions and patients, and staff attitudes towards this issue.***

Critique of medicine

The medical curriculum proved to be in no sense a homogeneous entity, and contained within itself some elements that were strongly critical of what was seen as the mainstream medical paradigm. The role of medicine and/or a critique of medicine was a theme that was looked at explicitly in 12 elements of the course, even if it was not said to constitute a major theme. Two people, both of whom taught specifically about some of the more radical critiques of medicine such as those of Illich, both thought that such issues needed careful handling if their treatment was not to alienate the students through apparent 'doctor bashing'. Health promotion might then take note of this caution, and take care itself not to present an overly negative view of doctors when working within medical education. It might also take note of the opinion, voiced by one of the staff who appeared to be able to tackle this issue with some success, that it is best to take a rather indirect approach, and allow the critique to be voiced by doctors rather than lay staff. It is clear that the need to recognise the limitations of medicine is an issue of which many doctors are aware, and which can be of interest to medical students if handled tactfully, in a way that keeps the students and the teacher on the same side.

Alternative paradigms within medicine

There was, perhaps more usefully for health promotion, a more pervasive critique of mainstream medicine coming from certain clinical specialties, particularly Primary Medical Care, Palliative Care, and Psychiatry. This group of specialties saw themselves as constituting an alternative, more holistic, 'low tech', patient centred and process oriented approach to medicine, in contrast to the more reductionist, 'high tech', doctor centred and facts based approach of mainstream medicine. Furthermore, Primary Medical Care and Geriatric Medicine perceived themselves as particularly interested in the psycho-social sciences, and Palliative Care particularly interested in the emotions of both patients and students. A different perspective, but still an alternative to mainstream medicine, came from Public Health Medicine, which was more interested both in prevention and in evidence based medicine than the mainstream specialities.

However all of the specialties that saw themselves as in some sense representing an alternative model, reported that they had status problems in the Medical School, problems to which their alternative perspective appeared to contribute. Staff from these specialties reported that students appeared to have some difficulty in reconciling the points of view they represented with that which they were hearing in other parts of the curriculum. They said that students often appeared to regress after a time away from their specialties, and tended to dismiss them as soft and low status.

Concerns about the role and power of the medical profession lie at the heart of the negative attitudes many psycho-social scientists have towards medicine (Johnson, 1972; Freidson, 1970; Navarro, 1976; Ehrenreich and Ehrenreich, 1978; Lupton, 1994). These negative attitudes are shared by many in health promotion in relation of to the involvement of medicine in their discipline (Turner, 1987; Willis, 1989; WHO 1986a; Bunton and Macdonald, 1992). It is cheering to discover that an awareness of the limitations of certain medical paradigms would appear to be by no means confined to psycho-social science and health promotion, but is shared by a sizeable proportion of specialties within medical education itself. It seems important then for health promotion to cease stereotyping all doctors and over simplifying the issues, and instead cultivate as allies and lend its support to those inside medicine who share many of its reservations about mainstream medicine.

The dismissal of commonsense knowledge

A theme which recurred often in relation to these alternative clinical approaches was that they tended to be dismissed by medical students, and even by some medical staff, as commonsense. It was, as we have said, an attitude which also permeated medical students' view of the epistemologies of the psycho-social sciences. It appeared that students drew much of their motivation to study from seeing medical education as imparting complex, specialist, closed, professional knowledge about issues to which the rest of the population

does not have access, namely physical disease, its symptoms and its bio-medical causes. They tended to see anything of which they were vaguely aware before they came to medical school, and anything in which other professions and the general public take an interest as automatically easy, obvious, and thus not worthy of their valuable time to study.

This is an interesting conundrum for health promotion, which appears to have to choose between emphasising its scientific, positivist, complex, technical side at the expense of its accessibility and links with the specialties that are most likely to support it, or emphasising its relationship to the everyday concerns of people and patients, at the expense of its status. It may at least take heart from the fact that it is not alone in this problem, which is shared by some clinical specialties. On balance it would seem best to stay on the side of the lower status specialties who are most likely to give support to the kind of social and empowerment models of health promotion that represent the best of the discipline, and join them in their struggle to gain status and recognition.

Critical thinking

An issue which those in Public Health Medicine connected with a discussion of the role and power of the medical profession was critical thinking. An interest in critical thinking was evident within the medical curriculum. The Public Health Medicine group saw promoting the skills of critical thinking and evidence based medicine as a central part of their role, and carried out some considerable teaching on it, certainly more than they did on health promotion. They reported that currently many clinicians seemed to find the evidence based movement threatening, but felt very much that the time for it had come.

Given the increased interest in critical appraisal and evidence based medicine in medicine as a whole, and given the concerns raised in this research, as elsewhere, by doctors about the evidence for the effectiveness of health promotion, it would seem important for health promotion to view the rise of the evidence based movement as an opportunity, not a threat. It needs to present research based evidence of the effectiveness of any actions or interventions it proposes. Fortunately, as the rationale chapter showed, there is a new emphasis in health promotion on the evidence base for its activities, which is now increasingly being collected and published (Gatherer, 1979; Liedekerken, 1990; Veen, 1995), and which needs to be more widely disseminated in medicine.

Teamwork and multi professionalism

- ***This thesis will examine the extent and nature of teaching about teamwork and the role and status of other health professions in the medical curriculum.***

Apart from a few seminar presentations, and most notably the major fourth year conference, in which students gave short conference papers on their project, students were taught very

little about communicating with one another. On the whole the teaching model in operation appeared to be that of competitive individualism. This finding may be of interest to those who would attempt to teach health promotion through cooperative team based projects (as for example, suggested by Joffe and Farrant, 1987), who need to be aware that students may find such approaches unfamiliar and difficult to adapt to, and perhaps not value as much as was intended.

Teamwork, either between doctors and other professions or between the students themselves appeared to be rarely taught explicitly, and the only references to it were, to the skills of leadership that the students were thought to need. This could be seen as reinforcing the very model of 'doctor on top' that many of those in health promotion, find so problematic (Kennedy, 1981; Zola, 1981; Strauss, 1984; Lupton, 1994).

Multi professionalism was apparently looked at in several elements of the course, and students were reported as meeting a wide range of professionals in the course of their undergraduate education. However such teaching was reported as representing only a very small part of the students' experiences: on the whole they were taught by hospital consultants, in the general hospital. Student reaction to contacts with other professionals was said to be variable. Students appeared to value and learn from their contacts with nursing staff, but were less enthusiastic about being taught by non health related professions, such as social work. The mixing of medical students in a 'one off' session with students from other professions produced a result that was highly negative, with medical students said to have ended up feeling angry and alienated by the 'doctor bashing' they received.

So if both medicine and health promotion attempt to promote greater teamwork and contact between medical students and other professions as an important element in professional development (Werner, 1978; Grant, 1987; Linkoping, 1988; Ramon, 1990; Baja, 1993) and if health promotion sees it as a way of helping build the healthy alliance culture and empowering the other health professions (DoH, 1993; Pringle, Fragstein and Craig, 1997), this will need handling with some care if students are not to be alienated from other professions, especially those who fall outside their immediate health service ambit. The same tensions that can plague intersectoral work among health professionals (Prentice, 1991; Ewles, 1993; Nocon *et al*, 1993) appear to affect medical students too. It appears important to recognise that mixing students from different professions is by no means an automatic recipe for success and, if attempted, needs careful thought and planning, and perhaps needs to happen frequently enough for students to work through their hostilities. Having a real task to perform, that requires genuine teamwork, might help to focus students' minds and help them see the true value of collaboration.

The students' own health

- ***This thesis will examine the extent and nature of teaching about, or a concern for, students' own health in the Medical School, and staff attitudes towards this issue.***

The students' own health received some coverage in the medical curriculum. There was particular awareness of mental health issues, reflecting previous research in this area (Richards, 1989; BMA, 1992 and 1993; Parker, 1990; Firth-Cozens, 1987). Some staff expressed strong anxieties about the level of stress students experienced, and what they perceived as a lack of awareness or concern about this problem by the medical school: some indeed felt that a culture of negativity and hostility created such stress, again echoing some of the concerns expressed in the literature (Bourgeois *et al*, 1993; Deary, 1994). The coordinator of the Palliative Care attachment very much recognised and attempted to tackle the deep problem of what Coombs (1986, 1991) has called *'disembodied intelligence'*, or the denial of emotion in medicine, which causes doctors not to recognise and deal with their own emotional needs.

Two of the third year attachments, Palliative Care and Primary Medical Care, attempted systematically to tackle the issue of student mental health, by helping students to cope with situations they found difficult, such as breaking bad news and talking to patients about cancer. Both Psychiatry attachments were said to cover student mental health issues opportunistically. In all cases students were said to appreciate this work. There was also said to be a working party recently set up to look at the issue of student stress. So it would appear that mental health, and particularly managing stress, was a felt need on the part of medical students, of which some staff at least were aware and about which some staff were attempting to take action. Almost all models of health promotion, be they behaviourist, empowerment or radical social change models, emphasise the need for professionals who are attempting to engage others in health promoting activities to examine their own health status and behaviours, and the need to 'care for the carers'. This research suggests that student mental health and stress management might provide some areas of mutual interest on which health promotion could build. Indeed such work is taking place in some medical schools already (Michie and Sandhus, 1994).

Several staff commented that students tended to seek out staff with whom they were comfortable to talk one to one about personal issues that worried or concerned them. Two members of staff felt that the structural arrangements for making this easy, in terms of an effective pastoral care system, were not present. It would seem that those interested in promoting the health of students might wish to lend support to efforts that are being made, some of which have been described in Coles (1993), to develop appropriate and sensitive

pastoral care and/or tutorial systems in Medical Schools.

In contrast with the interest in mental health, other, more physically related, health issues did not appear to have been so successfully tackled, but not apparently for want of trying. Efforts that had been made to introduce a range of student health issues, which could be described as 'looking after yourself', in the Foundation term were said to have mostly proved very unpopular with students, and only one input currently remained. However a session in the fourth year on the health risks students faced on electives was said to be very popular. It appeared therefore that students were only responsive to such messages if they perceived their immediate relevance, which is again an important lesson for those who would like to see such issues covered in medical education. It may be that young, healthy medical students are not much worried about their own physical health, and so to tackle such issues early on in their undergraduate years may be alienating: it may well be better to wait until they feel a little more under threat, for example when about to visit other countries, and then to concentrate on specific risks rather than health in general. From such a basis it may then be possible to move medical students on to a more generalised concern for their own health.

Teaching, learning and assessment

- ***This thesis will examine the attitudes and practices of the medical staff towards teaching, learning and assessment.***

The strong level of interest in the processes of medical education evidenced by staff was in line with the copious amount of research that has been carried out on the topic by medical educators, and which has now filtered through to those responsible for leading medical education at a national level (GMC 1993). All the elements of progressive thinking that were put forward in the King's Fund report on *'Critical Thinking'* (Towle, 1991) were certainly discussed with enthusiasm by many staff. They included the need to reduce the amount of factual information taught to students, to engage them in more active and self directed learning, to identify and teach core knowledge, skills, and attitudes, to teach and assess these domains through appropriate methods, and to plan and deliver the curriculum in a student centred manner. It would appear that staff very much intended to use the active and participatory methodologies of teaching, learning and assessment that tend to be associated with self empowerment approaches in health promotion. So there are strong links to be made between the two worlds, at the level of intention.

However it appeared that, in practice, there was a serious gap between staff intentions and the reality of their delivery. The curriculum the medical students experienced was said to be on the whole a traditional one, dominated by the need to learn and regurgitate factual

information, and assessed through formal written papers, multiple choice questions and confrontational vivas. The first two years appeared to be particularly traditional: although lecture time had been reduced it did not seem that much thought had been put into what else the students were to do. It appeared that staff had confused the idea of self directed learning with that of leaving students to their own devices. Of greatest concern was severe lack of small group teaching in those early years. It seems highly probable that the fears expressed by one coordinator in particular, that the students were treated as an 'anonymous herd', and the fears of several staff that students could suffer from severe stress without anyone knowing about it, seem very likely to be well founded. It certainly seems unlikely that students' experience of the first two years would have been a particularly empowering one.

So it is again regrettable that so much of the work on the psycho-social sciences, Public Health Medicine and on health promotion itself was located in those early, didactic years. The way in which such issues had to be transmitted was in direct contradiction to the methodologies that health promotion favours, although one can sympathise with the decision of the specialist lecturer responsible to teach her subject through the 'respectable' medium of the formal lecture, as this indeed appeared to be her only option.

On the positive side, it is good to note that Public Health Medicine, including prevention, and the psycho-social sciences issues made an appearance in all types of assessment. The view of many staff that this was increasing their status in the minds of the, inevitably exam oriented, students would seem likely to be true.

The clinical experience may well have been more positive and empowering from the students' point of view. Groups were smaller, and some specialties, such as Primary Medical Care and Palliative Care, and more surprisingly, Orthopaedics, talked of the need to treat them with warmth and a personal touch and to work with them on a one-to-one basis. There was some evidence that a few of what one coordinator called 'pockets' of teaching through sarcasm and ridicule still persisted, but some in the Medical School were concerned to eradicate this, and all those interviewed were very much against it. Some specialties, most notably Primary Medical Care, Palliative Care and Child Health had put considerable effort into the development of their teaching and staff development programmes. So it appears that from the methodological point of view that health promotion would again do better to look to the clinical years where groups are smaller and the ethos more student centred and humane, to develop its most effective interventions. This context would appear to give greater support for the kind of methodologies of teaching and learning it prefers and sees as necessary to support its particular insights and processes.

DEVELOPING THE TEACHING OF HEALTH PROMOTION ACROSS THE CURRICULUM

Enhancing specific inputs on health promotion in the medical curriculum

In the Medical School in question there was one common, compulsory, lecture on health promotion which appeared to be wide ranging, positive, to make use of many of the central concepts of health promotion, and delivered by a knowledgeable specialist from the discipline. However it is of concern that the amount of such teaching was restricted to one 50 minute lecture, to have been reduced in recent years from three lectures to one, and was solely reliant on a lecturer who, although extremely knowledgeable about health promotion, was not part of the permanent staff of the medical school and who therefore had no particular reason to feel allegiance to this part of her role.

Given the negative and restricted definitions most staff appeared to have of health promotion, it would seem desirable that there be some specific, substantial, and well informed input on what the subject is and what it means, so that students could be given clear and positive messages as a starting point. In this Medical School there would seem to be a need for the central, named inputs on health promotion to be expanded, better safeguarded and more widely disseminated, to staff as well as to students. Other medical schools may also share this need.

Greater coordination across the curriculum

Outside of the specific, named input in the specialist lecture, few staff conceived of themselves as teaching health promotion, although they did see themselves as teaching prevention in about half of the courses. Only two staff expressed a wish that teaching in health promotion and/or health education be better coordinated across the curriculum, and only two expressed the view that there should be more teaching and more emphasis placed on health promotion, and on positive health in general.

In this Medical School, health promotion would appear to be in need of clearer identification and coordination across the curriculum, including in the all important clinical specialties, ideally by someone who is both a senior, permanent member of staff and knowledgeable about health promotion (if indeed such a person exists) and certainly supported by a strong and influential team. The GMC has identified the need for powerful champions to push the cause of otherwise undervalued subjects such as the psycho-social sciences (GMC, 1987b). Health promotion was clearly in need of such support in the Medical School under review here, and may well be in need of such support in other medical schools.

Integration across a wide range of subjects has been the approach that has been advocated by the GMC for the psycho-social sciences as a whole (GMC, 1987b) and by most who

have written about developing health promotion in medical education (Weare, 1988b; Orbell and Abraham, 1993; Taylor and Moore, 1994; Pringle, Fragstein and Craig, 1997). It has been tried, with some success, in a range of medical schools (Weare, 1988b; Orbell and Abraham, 1993; Taylor and Moore, 1994). Taking a predominantly integrated approach to the development of health promotion would have the advantage of not contributing to the problem of overload, so often noted as a major issue in medical education (GMC, 1957, 1967, 1980, 1993), and of fitting in with a general drive to integrated curricula (GMC, 1980, 1993).

In this Medical School, some themes, such as nutrition, and communication, had been designated as vertical threads in the medical curriculum: that meant that they were not taught separately but were explicitly woven and coordinated through the subjects taught in the systems courses. Such an approach was generally talked of positively, and appeared to give a fairly high profile for the topics concerned. Health promotion and prevention did not enjoy this status. So in this Medical School, working to have health promotion designated as a vertical thread would seem to be a potentially useful way forward.

It may be that other medical schools have other mechanisms for integration that would be worth attempting to invoke in the attempt to embed health promotion more firmly in the curriculum.

The need to identify particular areas of the curriculum as key areas for development

Although coordination across the full range of subjects and specialties is the ultimate long term goal for health promotion, in the short and medium term it may be helpful to identify areas of the curriculum that would seem particularly fertile ground for development. The next sections will discuss the curriculum areas that appeared to be particularly significant in the development of health promotion in this Medical School: it may be that in other schools other areas are key, but the general principle of identifying potentially supportive curriculum areas and focusing attention on them would hold good.

The role of Public Health Medicine

This research interviewed all the staff who taught Public Health Medicine, rather than just the coordinator, in the belief that this specialty was particularly crucial to the delivery and status of health promotion in the Medical School. Most of those who have written about the teaching of health promotion in undergraduate medical education (Colditz, 1983; GMC, 1993; Pringle, Fragstein and Craig, 1997) and indeed the staff from the medical schools who responded to Randall's survey (Randall, 1988) have seen Public Health as having a particularly key role. In fact '*Tomorrow's Doctors*' seems to see health promotion as being entirely confined to this field (GMC, 1993).

In this Medical School, health promotion so called was indeed the responsibility of the Public Health Medicine group. It appeared that this location had some strengths and some weaknesses.

The Public Health Medicine group gave health promotion some positive support. They had appointed a specialist lecturer in the topic, and given her a clear slot for the subject. She felt that the group were gradually coming to understand health promotion more clearly, and to give it more respect, partly, she said, because she took care to emphasise the evidence for its effectiveness in terms of positivist models, emphasising the results of randomised controlled trials, and other such 'hard' research approaches. The Chair of the group was clearly highly knowledgeable about the health promotion, and very sympathetic towards it. Some of the fundamental perspectives that the group represented and taught, such as taking a population approach, prevention, epidemiology, risk and critical appraisal, are, as the rationale chapter has argued, essential parts of health promotion. The teaching coordinator talked of introducing work on healthy public policy, although it was clear that they had not yet done so. In terms of giving health promotion status in the Medical School, locating it in Public Health Medicine clearly gave it a better profile than would have been the case if it had been located in the psycho-social sciences, especially as the Public Health Medicine group had worked hard to improve their own status in recent years, an effort which was generally thought to have succeeded.

However, this location was not entirely supportive. It appeared that, apart from the Chair of the group, most of other the lecturers did not particularly value the teaching input on health promotion. The specialist lecturer reported that she was not involved in planning teaching, and had no idea why her three lectures had been reduced to one: this suggests that the security of this one remaining lecture might be in some doubt. She had not been asked to coordinate the subject through any other inputs, and no-one appeared to have thought of making it into a vertical thread. There was no mention of others in the group explicitly using the concepts she introduced, or even the term '*health promotion*' in their own lectures. Outside of the specialist lecturer, there appeared to be no teaching, or indeed research, being carried on about positive health, or about social aspects of health. Indeed, it was reported that the group left it to the Sociologists to teach social aspects of Public Health Medicine. The group, futhermore, appeared to confine their teaching to the formal, didactic lecture, and make even less use than did Psychology or Sociology of small group work and practicals.

This partial lack of support for health promotion may have been because most in the group did not appear to understand health promotion, or to be especially sympathetic towards it. One, for example, said that health promotion was seen by the group as rather *'soft, woolly and girly'*, a perception he appeared to share to some extent, seeing the theory of it as *'a bit commonsense; it's just putting it together in some conceptional framework'*. The lecturer

who was keen to develop more work on healthy public policy did not appear to link this idea with his concept of health promotion. It was clear that the main interest of the group was in epidemiology, which in practice tended to be the epidemiology of disease: indeed many of them appeared to see Public Health Medicine and epidemiology as synonymous. It may again be the case that the search for that all important status in the Medical School was leading this group to identify with the world of disease oriented, individualistic medicine, rather than value and support the work on positive and social health represented by the small voice of health promotion in their midst.

In the Medical School in question the role of health promotion within Public Health Medicine needed strengthening, perhaps through the Chair being persuaded to turn his sympathy for it into more active support, in terms of promoting it within his own group, by expanding the time devoted to specialist lectures on the topic, and by championing its establishment and integration in the curriculum in a more wholesale and comprehensive manner.

In all medical schools, health promotion will inevitably need the support and understanding of Public Health Medicine, as the interests of the two areas overlap so clearly (Colditz, 1983; GMC, 1993; Pringle, Fragstein and Craig, 1997). It seems important for those who would develop health promotion to engage in greater dialogue with Public Health Medicine, and attempt to ensure that specialists in this discipline understand what health promotion is about, value its contribution, and see how it permeates aspects of their discipline.

Health promotion and the clinical specialties

Given the greater status, relevance and lasting significance to medical students of the clinical as opposed to the basic sciences, it would seem particularly crucial to develop health promotion in the clinical years.

The most obvious place to build links in the clinical specialties was Primary Medical Care. Of all the mainstream clinical specialties, Primary Medical Care has traditionally tended to be linked with health promotion (Stott and Davis, 1979; Boulton and Williams, 1983, 1986; Randall, 1988; Coulter and Schofield, 1991). In this Medical School there were many ways in which Primary Medical Care supported health promotion, sometimes explicitly and sometimes without realising that they were. The 10 competences that underpinned the third year teaching included three about prevention and lifestyle change. One of its 7 seminars was on giving lifestyle advice. The teaching was almost exclusively concerned with communication skills, patient centredness, and holism. Teaching was very much based with GPs outside of the Medical School and in the community, and GPs were said by the teaching coordinator to teach about prevention. The group claimed to understand and have sympathy for the psycho-social sciences. They made use of some of the specialised language of health promotion, most notably the term 'empowerment'. They were the most

educationally aware of all the teaching groups, with their own extensive programme of staff development, and a clear grasp of the language, terminology and concepts of education, including those that relate to education for self empowerment. Their teaching of medical students was almost entirely in a small group, 'workshop' style, and they made use of some of the most educationally proven and sound approaches to the teaching of communication skills in particular.

But there was a barrier to any developments in Primary Medical Care which would need to be overcome: it was, as we have seen, the image that some of those in the group, had of what they variously termed '*health promotion*' and/or *'prevention'* and/or a *'population based approach'*. They saw it as opposed to their highly valued attitude of patient centredness, which may go some way towards explaining their overall tendency not to prioritise prevention and/or lifestyle advice that many of the Primary Care staff reported. The antagonism shown by staff towards the top down, interventionist model of health promotion imposed on them by government is very much in line with previous research (Kaufman, 1990). As we have suggested, convincing Primary Care staff that a range of other, bottom up, negotiated models of health promotion exist, and exploring their relevance for Primary Care might go some way to allaying this hostility. At the same time, it may also be helpful to relay to those who would impose health promoting roles on doctors, the negative impact such a top down approach appears to be having on GPs' perceptions of the value of health promotion.

The other specialties that particularly supported the key notions of health promotion, most notably through the work they had developed on communication, patient centredness and holism, included Child Health (which also incidentally was keen on positive health and prevention), Palliative Care, Geriatrics, Psychiatry, and Genito-Urinary Medicine. Child Health was interesting because, of all the specialties that supported these kind of approaches, it had high status. Palliative Care was particularly unusual with its effort to address and develop emotional aspects of medicine. All of these specialties would seem then to provide appropriate foci for development. So it is possible to identify some key specialties would also appear to offer particular opportunities for developing further work on health promotion, and would provide a promising environment in which to start an attempt at greater integration. It may be that in other medical schools, different specialties would prove to be particularly congenial. In general it would seem to be a sound policy to identify specialties that are already some way towards the goals of health promotion, and concentrate efforts to develop it in those contexts, at least initially.

SUMMARY AND CONCLUSIONS

This section will return to the main aims of the research, and summarise the key findings in relation to them.

OVERLAPS AND DIVERGENCES BETWEEN THE TWO WORLDS OF MEDICAL EDUCATION AND HEALTH PROMOTION

- ***The main aim of this thesis is to explore the relationship of the two worlds of health promotion and medical education. It will attempt to look at where the goals, content and processes of medical education overlap with those of health promotion, and where they diverge, in order to discover whether it is possible to bring them together into a more effective relationship.***

Overlaps

- Many of the aims of the medical curriculum were supportive of some of the perspectives of health promotion and the processes which underlie it. The medical curriculum was intended to teach about prevention, patient centredness, holism, communication, and to instill the attitudes of patient centredness, teamwork, and a critical perspective. There was also a formal intention to teach about positive health, and normality, as well as illness and disease. Staff intended to teach students skills and attitudes as well as knowledge, to teach them how to learn, and to be self directed and independent learners.

- There was some teaching about positive health in the psycho-social sciences and Public Health Medicine, and some teaching about normality in the basic sciences, and to a small extent in the clinical attachments, most notably in Child Health. Some staff, including some clinicians, expressed concern about what they saw as the over emphasis on disease and illness in the medical curriculum.

- Several clinical specialties worked with a concept that can be termed '*relative health*', which means helping patients to feel as 'well', and to do as much, as their current health status allows. This links with concepts of 'health as a continuum or spectrum' and 'health as a resource' that are current and well respected in health promotion.

- There was a strong interest by some clinical specialties in patient centredness. This involved empathy, seeing things from the patient's point of view, attempting to

understand their feelings, motivations, needs and beliefs, respecting their rights, dignity and autonomy. All clinical specialties paid at least lip service to the importance of patient centredness, and several saw it as fundamental to their practice. Such a perspective provides the basis for the development of self empowerment approaches.

- There was widespread acceptance of the importance of patient centred communication skills. There was some in depth teaching, particularly in Primary Medical Care, and latterly being spread to hospital specialists, of counselling type skills such as empathic listening, discovering, reflecting back, clarifying, using open questions, and involving the patient in the consultation. Such skills can be seen as constituting self empowerment, by another name.

- The specialties that actively supported a patient centred approach also tended to see the mental and emotional health of patients as having priority over their physical health status: this parallels the concerns of health promotion with mental and emotional as well as physical health, and the wish to avoid healthism.

- There was a strong interest by some clinical specialties in the idea of looking at and treating the whole person in their social context: called by both medicine and health promotion '*holism*'. Most clinical specialties paid it at least lip service to its importance. This provides a basis for a concern with social issues that is so fundamental to health promotion.

- The psycho-social sciences of Psychology and Sociology had a clear and established presence in the medical curriculum, both through teaching and through assessment. They taught many of the psychological and social issues and principles that are basic to health promotion, and staff who taught them were very knowledgeable about health promotion and its concerns.

- A few clinical specialties showed real understanding of and support for the epistemologies and insights of the psycho-social sciences.

- There was some interest in behaviour change in particular, and psychological approaches in general, including in a few clinical specialties. This included the recognition in the psycho-social sciences, and some recognition in a few clinical specialties, that 'telling people what to do' is not an effective way of changing behaviour or attitudes, and that more complex and sophisticated approaches need to be used.

- Public Health Medicine was well established in the medical curriculum, formed part

of the regular student assessments, and engaged in energetic and systematic teaching about epidemiology, risk, prevention and critical appraisal. All of those in the medical school took for granted the value and importance of teaching students about epidemiology and the concept of risk.

- There was a widespread interest in, and acceptance of the importance of teaching about, preventive interventions, especially those that have been proven through hard evidence, ideally through randomised controlled trials. There was some specific teaching about the giving of lifestyle advice, including in Primary Medical Care, and a widespread acceptance that this was a good use of a doctor's time.

- There was a specific, named input to the curriculum on the concepts and principles of health promotion, albeit small.

- There was a growing recognition, even by those clinicians who felt threatened by it, that medicine is having to concern itself with providing evidence for its effectiveness. This parallels the 'evidence based/ evaluation' movement in health promotion. There was some strong and committed teaching of the skills of critical thinking and evaluation by Public Health Medicine.

- There was a recognition of the limitations of the traditional medical paradigm, and the offering of an alternative perspective, by some of the clinical specialties, most notably Primary Medical Care, Palliative Care, Geriatric Medicine and Psychiatry. These specialities were keen to promote a low tech, patient centred and process oriented approach to medicine which is fundamental to a 'Health for All' perspective in both medicine and health promotion (WHO, 1985).

- Medical education is about to make a major shift away from its traditional base in the isolated world of the centralised general hospital, into Primary Medical Care, and smaller, local hospitals. This may support a greater emphasis on the community and social perspectives that underpin health promotion.

- There was some teaching of medical students by other health professionals, and some attempts to help them value the contribution of other professions. This parallels the concerns in health promotion to build 'healthy alliances'.

- There was some recognition of the importance of teaching students about their own health, and some attempts had been made to introduce this topic into the curriculum.

- There was some concern among staff about student stress, and some attempts to teach students to understand, accept and talk about their own emotions, and to help

them tackle situations they found stressful more effectively.

- There was a recognition of the need for the course to be 'student centred', to start where students are, and to treat them with warmth and respect. In particular, a great deal of attention was paid to soliciting and responding to student feedback on the course.

- Many staff were very interested in the development of sound educational methods and processes. There were positive examples of staff development occurring across the medical school. This links with the overwhelming interest in health promotion and health education in the 'hidden curriculum' of educational process and ethos.

Divergences

- There was, in practice, very little interest anywhere in the clinical elements in teaching about positive health. For health promotion, by contrast, positive health is its key focus and interest.

- There appeared to be conflicting definitions of health promotion held by those who specialise in health promotion and those who teach medical education. Almost all the doctors who taught the medical curriculum (although not the psycho-social scientists) saw health promotion as restricted to prevention and the giving of lifestyle advice. There was almost no recognition by doctors of empowerment models of health promotion, or the broader social structural approaches employed by health promotion, and they made no links between health promotion and issues of central interest to them as doctors, such as holism and patient centredness.

- There were concerns expressed by some clinicians that health promotion is a top down, imposed, and authoritarian activity, at odds with patient centredness.

- The psycho-social sciences, and particularly Sociology, were, on the whole, marginalised and not integrated into the medical curriculum, and were positively denigrated by some clinical staff. Mainstream medical education showed little support for or interest in the wider social structure, social change in general, the role of the doctor in bringing about social change, the 'settings' approach or 'healthy public policy'. Such community and social issues are, however, central to health promotion.

- The reflective, interpretive and relativistic epistemologies of the psycho-social sciences, which are those that tend to be favoured by health promotion, were seen by

many medical students and clinical staff as commonsense, easy, and not worth knowing, in contrast to the positivistic, facts based epistemologies of mainstream medicine, which were seen as technical, professional, difficult and conferring elite status and high social esteem.

- The parts of the curriculum that were most likely to support the concepts and principles of health promotion, such as patient centredness, holism, and communication skills, were also most likely to be seen as of lower status than those that concentrated on high tech, interventionist medicine.

- Despite its intentions, the process of medical education was still largely concerned with the transmission of facts, especially in the early years, and most of the assessments across the course as a whole involved the remembering of large amounts of factual material. In the early years, students were still mostly taught through lectures, and small group work was rare.

PRIORITIES FOR ACTION IN DEVELOPING HEALTH PROMOTION IN MEDICAL EDUCATION

- ***A secondary aim of this thesis is to suggest some strategies and priorities for action in developing health promotion in medical education.***

The following would seem to constitute the main practical messages for those who would develop health promotion in medical education:

Building a basis of mutual understanding

- There needs to be an appreciation of the many areas of overlap between medical education and health promotion. It is important to take a positive attitude to medical education and build on what is there, rather than starting from a negative, alienating, and confrontational point of view.

- There needs to be greater awareness that work called in a medical education context 'patient centredness' and 'communication skills' is likely to be self empowerment by another name. Those in health promotion could usefully work with those who are teaching about these issues, help them see the links with health promotion, and support them in their efforts to spread such approaches more widely across the medical curriculum.

- Some in medicine, and in particular those patient centred doctors with whom health promotion most needs to link, may perceive health promotion as itself top down and authoritarian. It is important to emphasise the person centred, voluntaristic and empowering orientation of the most well accepted approaches to health promotion.

- The notion of empowerment could be used to develop joint work on that explores the issues of voluntarism and autonomy in relation to both to health promotion issues such as 'giving lifestyle advice' and to medical interventions in general.

- There is a need for caution when using the terms '*health promotion*' and '*health education*' in a medical context, and a recognition that, for most doctors, these simply imply prevention and the giving of lifestyle advice, and that for some they have negative connotations. More precise terms that are more meaningful and familiar to doctors, such as *'holism'*, *'patient centredness'*, and *'effective communication'*, are more appropriate.

- Reorienting health promotion to illness, rather than trying to reorient medical education to positive health may produce a more productive dialogue between the two worlds, in the short term. Recognising and working with the joint area of interest represented by the idea of 'relative health' (i.e. helping people to be as 'well' as possible in the circumstances), while trying to draw medicine towards more positive models of health in the longer term, could be a useful strategy.

- Medicine should be included in, rather than excluded from, typologies of health promotion, giving it due recognition as part of the process of helping patients progress along the continuum of illness to health, of helping patients cope with their illness, live as well as they can, and cope with their limitations, and as one of the contexts in which health promotion takes place.

- It is best not to use the term '*medical model*' to describe approaches that are naive, simplistic and/or top down and authoritarian: alternative, more neutral and descriptive terminology such as '*traditional*' and/or *'functionalist'* acknowledges that there are many shades of belief and practice in medicine, including a widespread recognition of the complexity of health and illness, and the need for medicine to be patient centred.

- Many in medicine have reservations and criticisms about aspects of mainstream, 'high tech', hospital based medical practice. Those in health promotion could usefully cultivate them as allies, work with them to develop joint alternative approaches, and lend support to their efforts.

- It is important to avoid 'doctor bashing' when talking to medical students. Critiques of medicine may be better presented to medical students by doctors, especially high status clinicians, rather than by psycho-social scientists or health promotion specialists. If no-one suitable is available to teach it, it may well be a topic that is better left until medical students are not feeling so uncertain and vulnerable in their new role.

- When working in medical education, it is the responsibility of health promotion to be relevant to medicine, not vice versa. Those who work in medical schools should be familiar with the world of medicine, its tasks, its perspectives, its problems, its language, and constantly make sure that what they are saying is appropriate to a medical context.

- Employing tentative, interpretivist, and reflective styles of discourse may seem foreign and bizarre to medical students and to many clinical staff. If time is short, it may be better to use more facts based, positivist, scientific approaches.

- The rise of the evidence based movement in medicine can be viewed as an opportunity, not a threat. Those in health promotion should take care to present research based evidence, ideally from randomised controlled trials, for any claims about the effectiveness of any health promotion actions or interventions discussed.

- The concept of prevention is a familiar starting point to use when working with doctors, but it is important that approaches suggested have good research evidence behind them.

- Some doctors are starting to use a wider range of epistemologies, and are becoming interested in qualitative, reflective approaches. Those who are involved in health promotion could engage in mutually supportive dialogue and developments with these people, but should take care not to frighten them off by going too far too fast.

- For most people, including some of the most progressive in the medical profession, the promotion of mental and emotional health is at least as important as the promotion of physical health. Those in health promotion could emphasise the concern of health promotion with mental and emotional well being as well as with physical health, when working with clinicians.

- Medical students will probably not respond well to discussions about their physical health, being at the age when they think they are immortal. It is better to wait for opportunities when they feel more vulnerable, such as when starting clinical work

and worried about infection, or when going on attachments overseas, and build from there. Mental health and stress management would appear to be of greater interest to medical students. Those in health promotion could usefully make links with any work that is taking place already in medical schools on stress management, and/or pastoral care, for students.

- Broader social approaches are likely to be unfamiliar to medical students and clinicians, and/or alienating. It is best to build from a basis of an interest in 'holism', which implies a concern with the immediate social context in which real patients live, and the impact of that social context on the patient's health.

- Those in health promotion could make links with the psycho-social sciences, such as Psychology and Sociology, explore the overlap of content areas, and ensure that staff who teach these subjects understand the wide range of social, psychological and empowerment models that health promotion represents, so they can talk knowledgeably about it. These disciplines need supporting in their search for status and recognition in the medical school.

- It is important to be aware that the term '*psycho-social*' can have negative connotations for clinicians. In a clinical context, the term '*holistic*' may produce a more appropriate response.

- There are some very sound intentions within medical education to teach in ways that are empowering for students, and encourage them to think for themselves and explore skills and attitudes as well as knowledge. These intentions need to be recognised and used as the basis for mutual work, even if the practice of medical education sometimes falls short of the ideal.

When developing the curriculum:

- There need to be a few specific, named inputs on health promotion in the medical curriculum that clarify for students, and for other staff, what health promotion is about.

- Health promotion needs to be identified and coordinated across the curriculum, by a member of staff who is located in the Medical School and is themselves senior and/or is strongly supported by, senior members of the staff of the Medical School.

- Health promotion should be integrated into clinical specialities as well as the

preclinical and psycho-social sciences. If there is only time and energy to integrate into few places, the clinical context should have greater priority.

- It is useful initially to identify and concentrate particularly on developing health promotion in the parts of the curriculum that appear from their current work and orientation likely to provide a supportive environment for it. Primary Care and Public Health Medicine will probably have such a role in most medical schools, but other specialties may also be appropriate.

- It is best to be under, rather than over, demanding in requesting time in the curriculum: in crowded curriculum it may be better to be seen to do a little well rather than overreach and fail, alienating those who feel their subjects could do with more time.

- If it is reported that an innovation has been tried before and failed in the medical curriculum, it may well be true. In this case it is important to find out why the attempt failed and not make the mistake again. When devising planning teams it is wise to have members who have been in the medical school for some time, and have a sense of history, as well as those who are new and enthusiastic.

- In a climate where multi-professional work is rare, mixing students from different professions can be dangerous and, if attempted, needs careful thought and planning, and to happen frequently enough for students to work through their hostilities. Having a real task to perform, that requires genuine teamwork, may help to focus students' minds and help them see the value of collaboration.

- Medical students still tend to be taught within an ethos of competitive individualism, and via didactic methods, and asking them to work on cooperative team based projects or to engage in active group work may risk alienating them, or them not valuing the approach as much as was intended. It is best to fit the methodologies used to teach health promotion to those of the surrounding context, and ideally to work in parts of the curriculum where active, group work methods are used by mainstream subjects.

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APPENDIX 1

LETTER OF INVITATION TO INTERVIEW

Dear (name)

I understand from the medical curriculum booklet that you are the coordinator for the (name course/ attachment). I would very much like to interview you sometime in the next few months, if you would be kind enough to give me no more than an hour of your time.

I should like to talk to you about the course you are coordinating, its current nature and the place within it of teaching about health, health education and health promotion. My interest is not only in health and health promotion, but in the overall curriculum, as it is not possible or sensible entirely to separate content from process and context.

I am intending to interview all the coordinators of the courses that make up the medical curriculum. This will repeat a study I carried out a decade ago when in 1985 I interviewed all the coordinators and some others, who were kind enough to be generous with their time and frank in their discussions. I hope that adding this longitudinal comparison will make a worthwhile study, that is of use to the medical school, and to medical and health professional education more generally.

I should like to tape the interview, with your consent. If you have any course materials, such as handbooks or handouts that would help me understand your course better I should be most grateful to have them on loan.

My secretary will phone you or your secretary shortly to see if it is possible to make an appointment between now and Easter. If you do not wish to see me, or feel you are not the right person for me to talk to, then please tell her then, or drop me a line or phone in the meantime. Otherwise I look forward to seeing you.

Yours sincerely

Katherine Weare
Director of the Health Education Unit

APPENDIX 2

Interview schedule

Interview with: **On:**

Coordinator of :

Preliminaries

- *Are you still the coordinator of the course? For how long have you been doing this?*
- *If someone else is, or was recently, who are they?*
- *Are you involved in any other courses as coordinator or teacher?*
- *State aims of the interview*
- *State who I am*

About the course in general

- *What are the aims of the course?*
- *Has there been any change in these aims, or in the overall emphasis of the course?*
- *Can you give me a 'thumbnail sketch' of the course/ attachment? What content does it cover? How is it structured?*
- *Is there any documentation I can have to help me understand it?*
  (Note here what is wanted back)

- *Has the course changed over the last ten years or so? If so, how?*

- *How is the course taught? What methods do you use?*

(if stuck, say for example 'lecture/ seminar/ practical/attachment/ self directed learning/ one to one?')

- *Has there been any changes in these methods?*

Questions on specific aspects

Turning now to some of the areas in which I am particularly interested, such as health, health promotion, social issues and so on....

- *To what extent does the course take a holistic view and/or cover psycho-social issues?*

- *Does this course include anything on prevention?*

- *Is there any work on 'healthy lifestyles'?*

- *Does this course include anything on health promotion, that you have not mentioned already?*

- *It is often said that the medical curriculum is essentially about disease and illness. Do the students get any messages about positive health, normality, or well being?*

- *Is there any sense in which the students' own health is mentioned?*

- *Does the course teach communication skills at all?*

- *Do the students see any examples of teamwork or work with other professions on the course?*

- *Is any use made of community as the context for teaching?*

- *Do you hope the students will acquire any particular attitudes to patients?*
- *How are students assessed?*
- *How do students give feedback on the course?*
- *Are any particular attempts made to integrate this course with any other, vertically or horizontally?*

Final questions

- *Have you any wider thoughts on?....*
  - *On the course we are looking at*
  - *On the year in which the course takes place*
  - *On the medical course at Southampton*
  - *On medical education in general*
- *Is there anything you feel I left out that I should have asked you?*
- *Is there anyone else you think I should speak to?*

Thank you very much

Note - to do next:

APPENDIX 3

BREAKDOWN OF AIMS ACCORDING TO HOW THEY APPEARED IN THE SEPARATE COURSES

1st and 2nd year basic science courses √ = written in med curr.booklet. ☺ = said in interview

COURSE AIMS: learning.....	yrs 1 &2	term 1	term 2	term 3	term 4	term 5	term 6
knowledge and understand. about the body	☺	√ ☺	√ ☺	√ ☺	√ ☺	√ ☺	√ ☺
to understand disease (stated specifically)		√	√ ☺	√ ☺		√	√
about health/ normality (stated specifically)							
to integrate basic sciences with clinical				√ ☺	√ ☺	√ ☺	☺
about medicine as a whole							
about a particular speciality/ service							
history and examination							
to diagnose/ detect disease							
management / treatment of disease							
'clinical skills'						☺	☺
understanding psycho-social science/holism		√		√ ☺			
about the determinants of health		√	√				
patient centred approach		√			√		
positive attitudes to particular patients							
communicate with patients and families	☺						
doctor/patient relationship/ role of doctor	√						
public health/ epidemiology			√		√		√
about prevention			√				√
about lifestyle/ behaviour change			√				
about own emotional/ social needs		☺	☺				
to learn/ self learning	☺	√ ☺	☺				
to think critically, weigh evidence		√				√	
to communicate with colleagues		☺					
reflect /to have a broader vision	☺	☺	☺				
sexual health							
pregnancy/ childbirth/ development				√			
ageing/ death and dying							
disability							
team working/ multi professionalism							
ethics							
other							√

Early Patient Contact √ = written in medical curriculum book ☺ = said by coordinator in interview

COURSE AIMS: learning.....	EPC PMC	EPC Human Rep.
knowledge and understand. about the body		
to understand disease (stated specifically)		
about health/ normality (stated specifically)		√
to integrate basic sciences with clinical		
about medicine as a whole		
about a particular speciality/ service		
history and examination		
to diagnose/ detect disease		
management / treatment of disease		
'clinical skills'		☺
to take a psycho-social perspective	√	
about the determinants of health	√	
patient centred/ holistic approach	√ ☺	√ ☺
positive attitudes to particular patients		
communicate with patients and families		√ ☺
doctor/patient relationship/ role of doctor	√	
public health/ epidemiology		
about prevention		
about lifestyle/ behaviour change		
about own emotional/ social needs		
to learn/ self learning		
to think critically, weigh evidence		
to communicate with colleagues		
reflect /to have a broader vision		
sexual health		
pregnancy/ childbirth/ development		√
ageing/ death and dying		
disability		
team working/ multi professionalism		
ethics		
other		√

Year 3 (cont. over) Key: √ = written in medical curriculum book ☺ = said by coordinator in interview

COURSE AIMS: learning.....	yr 3	CFC	S-BOM	Child Heal.	PMC	Geriatrics	Med
knowledge and understand. about the body							
to understand disease (stated specifically)							√
about health/ normality (stated specifically)				√ ☺	☺	√	
to integrate basic sciences with clinical	√ ☺	☺	√ ☺	√ ☺		√	√ ☺
about medicine as a whole		☺			☺	☺	√ ☺
about a particular speciality/ service				☺	☺		☺
history and examination	√ ☺	√ ☺		√ ☺	√ ☺	√	√
to diagnose/ detect disease					√		√
management / treatment of disease					√		
'clinical skills'	☺	√ ☺	☺				
understanding psycho-social science/holism				√ ☺	☺	√	
about the determinants of health				√	√ ☺		
patient centred approach	√ ☺	√ ☺		√ ☺	√ ☺	√ ☺	
positive attitudes to particular patients						☺	
communicate with patients and families	☺	√ ☺		☺	√ ☺	√	
doctor/patient relationship/ role of doctor							
public health/ epidemiology		√					
about prevention				√ ☺	√ ☺		
about lifestyle/ behaviour change					√ ☺		
about own emotional/ social needs		√				√	
to learn/ self learning					☺	√	
to think critically, weigh evidence		√			☺		
to communicate with colleagues		√ ☺					
reflect /to have a broader vision		√			☺		
sexual health					☺		
pregnancy/ childbirth/ development		√ ☺					
ageing/ death and dying						√ ☺	
disability			√			√	
team working/ multi professionalism		√				√	
ethics		√	√				
other							

Year 3 (cont) Key: √ = written in medical curriculum book ☺ = said by coordinator in interview

COURSE AIMS: learning.....	O &G	Pallia tive	Psych iatry	Surg- ery
knowledge and understand. about the body				
to understand disease (stated specifically)			√	☺
about health/ normality (stated specifically)				
to integrate basic sciences with clinical	√ ☺		√	√
about medicine as a whole				
about a particular speciality/ service			√ ☺	
history and examination	√ ☺		√ ☺	√ ☺
to diagnose/ detect disease	√		√	√ ☺
management / treatment of disease	√		√	☺
'clinical skills'	√			√
understanding psycho-social science/holism		√ ☺	√ ☺	
about the determinants of health				√
patient centred approach		√ ☺	√	√
positive attitudes to particular patients		√ ☺	√	
communicate with patients and families		√ ☺	√	
doctor/patient relationship/ role of doctor				
public health/ epidemiology			√	
about prevention			√	
about lifestyle/ behaviour change				
about own emotional/ social needs		√ ☺	√	
to learn/ self learning				
to think critically, weigh evidence			√	
to communicate with colleagues			√	
reflect /to have a broader vision				
sexual health				
pregnancy/ childbirth/ development	√ ☺			
ageing/ death and dying		√ ☺		
disability				
team working/ multi professionalism		√	√	
ethics				
other				

Year 4 Key: √ = written in medical curriculum book ☺ = said by coordinator in interview

COURSE AIMS: learning.....	Proj-ect	Derm	Eyes	GU	Neuro	Ortho	ENT
knowledge and understand. about the body		√					
to understand disease (stated specifically)							
about health/ normality (stated specifically)							
to integrate basic sciences with clinical			√				
about medicine as a whole							
about a particular speciality/ service		√ ☺		√			
history and examination		√	√	√ ☺	√ ☺	√ ☺	√ ☺
to diagnose/ detect disease		√	√ ☺	√ ☺	√	☺	☺
management / treatment of disease		√	√	√	☺		
'clinical skills'				√			
understanding psycho-social science/holism		√					
about the determinants of health		√ ☺		☺			
patient centred approach		√		√			
positive attitudes to particular patients							
communicate with patients and families				☺			
doctor/patient relationship/ role of doctor							
public health/ epidemiology							
about prevention							
about lifestyle/ behaviour change							
about own emotional/ social needs							
to learn/ self learning	√ ☺						
to think critically, weigh evidence	√ ☺						
to communicate with colleagues	√ ☺						
reflect /to have a broader vision	√						
sexual health				√ ☺			
development							
ageing/ death and dying							
disability							
team working/ multi professionalism							
ethics	√	√		☺			
other							

Year 5 Key: √ = written in medical curriculum book ☺ = said by coordinator in interview

COURSE AIMS: learning.....	Yr 5	Child Heal.	PMC	Med.	O&G	Psych	Surgery
knowledge and understand. about the body						√	
to understand disease (stated specifically)		√	☺	√			☺
about health/ normality (stated specifically)					√		
to integrate basic sciences with clinical							
about medicine as a whole							
about a particular speciality/ service		☺	√ ☺		☺	√ ☺	√
history and examination		☺	√ ☺	√	√ ☺	√ ☺	√ ☺
to diagnose/ detect disease		√ ☺	√ ☺	√	√ ☺	√	☺
management / treatment of disease			√ ☺	√		√ ☺	√ ☺
'clinical skills'	√			√	☺	☺	
to take a psycho-social perspective/holism		√	☺		√	√	
about the determinants of health		√					
patient centred/ holistic approach			√ ☺				
positive attitudes to particular patients				√			
communicate with patients and families			☺				
doctor/patient relationship/ role of doctor							
public health/ epidemiology						√	
about prevention							
about lifestyle/ behaviour change							
about own emotional/ social needs							
to learn/ self learning							√
to think critically, weigh evidence				√			
to communicate with colleagues							
reflect /to have a broader vision							
sexual health							
pregnacy/ childbirth/ development							
ageing/ death and dying							
disability							
team working/ multi professionalism			√ ☺				
ethics							
other			√				√

Course as a whole Key: √ = written in medical curriculum book ☺ = said by coordinator in interview

COURSE AIMS: learning.....	Course as a whole
knowledge and understand. about the body	√ ☺
to understand disease (stated specifically)	√ ☺
about health/ normality (stated specifically)	√ ☺
to integrate basic sciences with clinical	√ ☺
about medicine as a whole	√ ☺
about a particular speciality/ service	
history and examination	√ ☺
to diagnose/ detect disease	√ ☺
management / treatment of disease	√ ☺
'clinical skills'	√ ☺
to take a psycho-social perspective/holism	√ ☺
about the determinants of health	
patient centred approach	√ ☺
positive attitudes to particular patients	
communicate with patients and families	√ ☺
doctor/patient relationship/ role of doctor	
public health/ epidemiology	
about prevention	√ ☺
about lifestyle/ behaviour change	
about own emotional/ social needs	√ ☺
to learn/ self learning	√ ☺
to think critically, weigh evidence	√ ☺
to communicate with colleagues	√ ☺
reflect /to have a broader vision	☺
sexual health	
pregnancy/ childbirth/ development	√ ☺
ageing/ death and dying	√ ☺
disability	√ ☺
team working/ multi professionalism	√ ☺
ethics	√ ☺
other	√

APPENDIX 4

Examples of how the original verbatim aims were categorised for table F1.

COURSE AIMS: learning.....	**Written aims** (from medical curriculum book)	**Oral aims**
Knowledge and understanding about the body/mind	Term 5: '*To provide a basic understanding of the principles by which the three major systems covered in this term operate together with sufficient factual material to enable the student to attain a good basic understanding of the subjects upon which they will be able to build in the future'.*	Term 6 coordinator: *'Teaching them the basic sciences that go with gastro-intestinal and lymphoid system, anatomy, physiology and all that.'*
To understand disease (stated specifically)	Term 1: *'To understand how the normal functions of the cells and tissues may be disturbed by adverse intrinsic (genetic) and extrinsic (environmental) influences'*	3rd year Surgery coordinator: '*They will be expected to be able to elicit symptoms in surgical patients and become familiar with disease processes.'*
About normality (stated specifically)	Early Patient Contact, Human Reproduction: *'To observe labour and delivery in the normal patient. To learn from the patient about her concerns about the labour, birth and her immediate plans for the baby thereafter.'*	3rd year Child Health coordinator: *'To understand the range of normality, which is a major issue for us'*
Integrate the basic sciences with clinical practice	Geriatric attachment: *'Students will consolidate skills in integrating clinical and preclinical scientific knowledge.'*	3rd year Obstetrics and Gynaecology coordinator: *'Taking the basic sciences and bringing them into the clinical context of womens' health and disease'*.
About medicine as a whole/ general medicine	3rd year medical attachment: '*The student will be expected to acquire a core knowledge of common medical conditions'.*	Geriatric medicine coordinator: *'Trying to learn general medicine in older people'*
About a particular speciality/ service	4th year Dermatology: *'To gain an appreciation of the specialist skills available in a dermatology department'.*	5th year Psychiatry coordinator: *'To give the students a flavour of the speciality, and it's nice if we can attract good people into it.'*

To take a history and do a physical examination	Year 3 as a whole: *'To begin to learn the basic skills of history taking and physical examination'.*	Neurology coordinator: *'To make the students competent at taking a neurological history and doing an examination and be able to interpret the signs'*
To diagnose/ detect disease	3rd year Psychiatry: *'To acquire basic knowledge of the symptoms and signs, causes, natural history, cause and prevention of the major clinical syndromes in psychiatry/ learn to evaluate a patient's presenting complaints and arrive at an appropriate assessment of the case, including a differential diagnosis.'*	Genito-Urinary coordinator: *'To teach students that STD work is not about just guessing, it is about making important structured diagnoses.'*
About the management / treatment of disease	5th year Medicine: *'To develop the skills of patient management, including therapeutics/ to be able to answer questions...on the natural history, investigation and management of disorders.'*	5th year Surgery coordinator: *'To take them through the treatment of the surgical patient at a higher level of management we expect from the third years'.*
'Clinical skills' (details unspecified)	Clinical Foundation course: *'To learn the basic routine for clinical assessment'.*	Genito- Urinary coordinator: *'Assessment not diagnosis, treatment, follow up..let them do that side of things if they want'.*
To take a psycho-social/ holistic perspective	See tables F10, F13 and F15.	
About the determinants of health and illness	Early Patient Contact, Primary Medical Care: *'To illustrate the ways in which psychological, sociological and physical factors may all interact and contribute to illness'*	3rd year Child Health coordinator: *'To recognise a range of problems responsible for ill health in children.'*
To take a patient centred approach	See table F17.	
To have positive attitudes to particular patients	3rd year Psychiatry: *'To develop an attitude of confidence and professionalism in dealing with the mentally ill.'*	3rd year Geriatric Medicine coordinator: *'To give students positive attitudes to geriatric patients, not see them as a separate lot.'*
To communicate with patients and their families	See table F18.	
The role of the doctor	See table F19.	

Public health/ epidemiological perspective	See table F12.	
About prevention	See table F10.	
About lifestyle/ behaviour change	See table F10.	
(Meeting) students own emotional/ social needs	Palliative Care: *'To survive emotionally themselves both as students and after qualification/ to have an enjoyable and stimulating week.'*	Foundation term coordinator: *'To help the students settle in and form groups and get peer support.'*
To learn/ self learning	5th year Surgery: *'They should be encouraged to continue their personal education by the use of hospital library facilities.'*	Term 2 coordinator: *'To try and give them things that will challenge them intellectually'*.
To think critically, to evaluate, to weigh evidence	Term 5: *'Experimental evidence is included so that the student is able to assess the veracity of the mechanisms proposed'*.	4th year Study in Depth coordinator: *'To give them an experience in research basics.... look at original papers in the library and they get to design a piece of research, they get to handle the data and do statistics.'*
To communicate with colleagues	3rd year Surgery: *'Students are expected...to be able to communicate their findings in written and oral presentations.'*	Clinical Foundation Course coordinator: *'To talk to other health professionals'*
To reflect /to have a broader vision	Clinical Foundation course: *'To give students a community perspective.'*	Foundation term coordinator: *' Help students see that there is more to being a competent doctor than knowledge...and more to life than a lecture theatre.'*
About sexual health and disease	Genito-Urinary Medicine: *'To provide practical experience in history taking, examination, microscopy and treatment of patients with genital infection and HIV diseases.'*	3rd year Primary Care coordinator: *'We do some things on sort of sexual health.'*
About pregnancy, childbirth, development	Child Health: *'To introduce students to the concepts of growth and development of both well and ill children.'*	Early Patient Contact, Human Reproduction coordinator: *'We want the student to see a woman, usually with her partner, in labour, and have the experience, perhaps the first time they might have seen in the flesh a woman having a normal delivery.'*

About ageing/ death and dying	Palliative Care: '*To understand the role of the multi-professional team in caring for dying patients at home and in hospital.*'	Geriatric Medicine: *'Whatever branch of medicine they go into they will at least have reasonable attitudes towards elderly people*'.
About disability	Child Health: *To introduce students to.. the care of the disabled child.*'	(Not stated orally as an aim.)
About team working/ multi professional practice	See table F21.	
About ethics	Clinical Foundation Course: 'To learn about ethics, professional etiquette and the legal status of students.'	Genito-Urinary coordinator: '*To teach them the importance of confidentiality, the responsibilities of the doctor and the interface between managing the individual and managing the community and the ethical lines and dilemmas that can generate*'.
Other/ one offs	Term 6: *'To provide the legally required course of instruction in radiation biology.'*	(Not stated orally as an aim.)