GPs saw homosexuals as effeminate – another of Dressler's stereotypes. There is no clinical evidence to suggest that such is the case. It would have been useful to have included a question about the degree of contact the individual doctor had had with a homosexual. Both groups agreed overwhelmingly with the statement that the subject had not been adequately covered in their medical school curriculum.

The present study shows some of the attitudes prevalent among the medical profession before the Human Immunodeficiency Virus [HIV] became recognised in the UK. A study is currently under way to investigate the attitudes since the AIDS epidemic became established. The questionnaire needs to be validated with interviews for subsequent use. The attitudes in the present survey may provide a baseline which can be checked regularly in association with attributional factors for these beliefs.

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The University of Leicester new MRCPsych academic programme

MERVAT NASSER, Senior Lecturer, University of Leicester and Consultant Psychiatrist, South Lincolnshire Health Authority; and TRAOLACH BRUGHA, Senior Lecturer, Department of Psychiatry, University of Leicester, Clinical Sciences Building, Leicester Royal Infirmary, PO Box 65, Leicester LE2 7LX

Since the establishment of a separate Royal College of Psychiatrists and membership examination, psychiatry has been progressively acquiring a special identity of its own that bridges the social and biological sciences. The University of Leicester Psychiatric Training Scheme has responded to the recently revised Membership Examination by developing a two year modular academic programme, which complements the traditional medical (diagnostic) organisation of teaching by incorporating social and psychological views of the subject, which reflect the lessons of modern psychiatric research. It is hoped that the development of a more eclectic approach to the subject and its practice will complement the multidisciplinary and growing community orientation of the profession. We describe here our first attempts to provide an academic programme that responds sympathetically to these important developments.

Background

The first membership examination was held in 1972. It was closely modelled on the pattern of the diplomas in psychological medicine and remained so for almost a decade. In 1981, however, voices within

the College urged reform, which led the College to appoint a working party to review the existing examination and make necessary recommendations for a new one (1985). The main objections to the old examination were the following:

(a) The absence of any clinical test from the time the trainees enter psychiatry until they take the membership examination, three years later.
(b) The temptation, for the candidate, to disregard the sciences basic to psychiatry once the preliminary test has been passed.
(c) The limited reliability of the marking of the essay paper.
(d) The fact that the examination is not sufficiently linked to the educational process.

The most important recommended change was the shift of emphasis between the preliminary test and the membership exam, whereby the preliminary test would be an examination in basic clinical psychiatry, in which the candidate would be expected to demonstrate knowledge of the subject, including relevant aspects of the basic sciences, as well as the clinical skills required for psychiatric assessment. As for the membership examination itself it was decided to retain the format of the old one. In addition to the clinical topics of general adult psychiatry, child psychiatry, psychogeriatrics, forensic psychiatry, mental handicap and psychotherapy, knowledge would also be required in the basic sciences of psychology, clinical pharmacology, social studies, epidemiology and genetics. It was recommended that emphasis should be placed on the application of concepts to the understanding of abnormal phenomena and the candidate should understand the ways in which ideas and techniques, from several disciplines, can be used to investigate a single problem of clinical interest.

The recommendations were accepted as necessary steps toward the new examination, which was finally introduced in October 1987. The new examination undoubtedly could be seen as having adequately overcome the pitfalls of the old one. It is important, none-the-less, to see whether changes in the format of the examination have influenced the teaching programmes administered by university departments throughout the country, to make the examination relevant to the educational process.

After the introduction of the new examination attention was focused on the preliminary test, as it was obvious that a different approach would be required of candidates. Emphasis was placed on improving teaching in interviewing skills and developing the candidate's sensitivity in clinical settings and teaching trainees the grammar of the clinical assessment. The membership examination did not receive comparable attention, perhaps as it was perceived deceptively as not being all that different from the old one.

Revised academic programme

Organisers of the Leicester University membership teaching programme thought it important to redesign the form of the programme and thus to capture the spirit of the new examination. The full programme was started in autumn 1988 as a new form of combined and integrative teaching, and followed several phases of written and oral consultation with trainees, teachers and representatives of all the major sub-specialties. The importance of collaboration with sub-specialties and with other disciplines was realised from the beginning and adhered to throughout.

Teachers are drawn from general psychiatry, the psychiatric sub-specialties, as well as academic and clinical departments of psychology, social science, epidemiology and the basic sciences. A modular approach to teaching has been devised, which partly represents a departure from the traditional diagnostic model approach to topics. It was deliberately chosen in an attempt to marry a wider range of theoretical concepts and scientific methods to ordinary clinical practice. The traditional (medical model) diagnostic formulation is taught where appropriate in conjunction with social, learning, developmental and other models of practice, thus reflecting the growing scientific knowledge of the strengths and deficiencies of the medical model. The teaching takes the form of tutorials, highlighting the importance of interactive teaching as opposed to didactic teaching. The use of audio-visual techniques, particularly in teaching assessment, interviewing skills and psychotherapeutic skills, is encouraged. Handouts are given as well as relevant reference lists. Students are expected to have read the appropriate textbook and specified additional material to enable them to participate actively in the seminars. Traditional case conferences continue to take place as before; and each trainee is responsible for a detailed presentation of a key paper in the recent clinical or scientific literature, approximately twice during each academic year.

The new programme is summarised in the Table. It consists of three modules; each module takes two academic terms, consisting of approximately 24 half-day sessions per module.

Module 1 – *Determinants and Explanations*

The first module begins with an introduction to the philosophy of sciences, the concept of health and disease and the theory of causality. It then proceeds to the basic principles of the scientific method: including measurement, experimental design and interpretation. The measurement and classification of psychiatric disorders is then covered in relation to child and adult psychiatry. Epidemiological principles, both descriptive and analytical are dealt with. The design and interpretation of case control studies

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surveys (cross-sectional and longitudinal) is followed by risk factors in mental illness, including genetic factors, physical, organic and social factors. Selected concepts in sociology are taught, which include the definition of society, social policy, social class, employment, urbanisation and immigration. The role of social support, 'stress' and stressful life events is also covered in this term, in relation to all forms of illness.

The second term of the first module deals with both the neuro-sciences and psychology. The basic principles of neuro-chemistry are linked to neuro-pharmacology and the study of cerebral-pathology, which is taught in connection with its psychological manifestations. Emphasis is placed on combining the theoretical principles of psychology with applied psychology. Concepts of personality development including the contribution of psychoanalytic theory, the development of sociability, langauge, cognition and intelligence are also covered. The theory of learning is taught in conjunction with the principles of behavioural psycho-therapeutic techniques.

Module 2 – *Investigations*

The second module is intended to promote the necessary knowledge and skills required to detect morbidity through a variety of investigative methods. This starts with the technique of history taking (including the developmental history) and mental state examination. Emphasis is given to the study of normal and abnormal phenomena of the mind. The concept of clinical assessment is enlarged to cover specific problems with particular categories of patients, for example, the elderly, the mentally retarded and the dangerous patient. Assessment of child abuse and neglect as well as assessment of the family, marriage and sexual behaviour are also included.

The second term of this module deals with source investigations and special investigations. The relationship between the psychiatrist and primary health care is explored as well as the concept of liaison psychiatry. Social work investigations, psychometry, clinical investigations and neuro-radiological investigations are integral parts of this module.

Module 3 – *Management*

The emphasis in the third module is on the eclectic management of the individual patient, couple or family. Issues related to the Mental Health Act and the nature of informed consent are tackled in this context. Physical methods of treatment are well covered here including pharmaco-therapy and ECT. Certain issues, in relation to drug treatment, such as the interpretation of the results of drug trials, ethical aspects of the relationship of doctors with the pharmaceutical industry and the cost effectiveness of drugs are all dealt with. The nature and function of physical methods of treatment is followed by psychological methods, including behavioural, cognitive and insight orientated interventions in relation to the individual, group and family.

The second term of this module is concerned with the variety of institutional and community care. Teaching is geared towards rehabilitation, resettlement and long-term care. Towards the end of the term the trainees are taught how to formulate management plans and how to follow the style of a problem orientated medical record, while retaining the deliberate and conscious use of the traditional diagnostic formulation.

The problems involved in managing community care facilities as well as the assets of and the difficulties encountered in the multidisciplinary team are discussed and openly debated. The management structure of health service systems, policy, planning, implementation and evaluation are covered briefly.

TABLE I

Module 1
Determinants and explanation
- Philosophy of science and the scientific method
- Disease concept and psychiatric classification
- Epidemiology – descriptive
- Epidemiology – analytical
- Psychology
- Social Sciences
- Neuro-sciences

Module 2
Investigation
- Social and cognitive development
- Normal and abnormal mind – clinical syndromes
- Marriage, work and family relationships
- Special problems – dangerousness – child abuse – substance abuse etc.
- Clinical investigation, neuro-radiology and psychometry
- Additional investigations and sources of information

Module 3
Management
- Ethical issues – consent and compulsory treatment
- Physical methods of treatment
- Psychological and social approaches
- Formulating, implementing and evaluating management plans
- Preparing medical reports
- Planning and policy making

Comment

It is too soon to assess the programme's acceptability to teachers and trainees. The third module has been run once in a pilot and modified form and at the time of writing the first module is nearing completion. In principle, the trainees as a group, have welcomed the

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planned changes. Some participants are concerned about their prospects as examination candidates but the weekly case conferences and additional small group and one to one teaching on 'examination tactics' appear to serve the purpose of identifying and rectifying any areas of weakness.

We would welcome enquiries as well as comments from colleagues in other training schemes.

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Comment

Every postgraduate teaching scheme in psychiatry has had to revise its formal teaching programme following the introduction of the new College Membership Examination. It is likely that widely differing approaches have been adopted, and the paper in which the Leicester University Membership Teaching Programme is described in detail is timely and of considerable interest. I am grateful to you for asking me to comment on it.

Drs Nasser and Brugha are to be congratulated on their initiative in producing a scheme which reflects closely the spirit of the new Membership Examination. Their departure from the more traditional didactic approach of formal lectures is particularly refreshing. They have thought carefully too about the need to acquire skills in the community, particularly those concerned with understanding social policy and systems of care relevant to social services, other professionals and voluntary agencies. The trainee psychiatrist of today needs to learn such a wide spectrum of expertise in order to be effective and credible over an extended front. Of paramount importance, however, is the acquisition of clinical skills in relating to patients, and the Leicester scheme rightly focuses on these at an early stage.

Without doubt, training schemes will vary a great deal in the way the formal academic element of training is organised. All schemes will need to deal with basic clinical issues in time for the Part I Examination, that is, in the first year of training. The inclusion of some sessions on basic clinical neurological assessment is probably advisable within this year, and candidates should also be made aware of the importance accorded to selective physical examination, where appropriate, in the Clinical Examination. Some schemes might choose to be more selective than the approach adopted in Leicester in preparing candidates for the Part II, and focus only on selected topics, perhaps those that are found difficult to read and learn about. Candidates everywhere will of course be expected to read widely under their own initiative, and no formal teaching programme can replace that.

A warning might be appropriate at this stage concerning the need to address very carefully the problem of teaching basic sciences, particularly in preparation for the Part II Examination. The generally low standard of candidates' knowledge in matters such as statistics, psychology (especially developmental) and neurosciences must mean that having successfully adjusted to the new Part I Examination, we still have a great deal to do in helping candidates prepare for such topics, mainly in the Part II. The new Examination does not require encyclopaedic knowledge, but candidates will certainly need to show that they are reasonably well informed on basic issues.

H. G. MORGAN
Chief Examiner