This is the published version of a paper published in *Nordic Journal of Psychiatry*.

**Citation for the original published paper (version of record):**

Trainee editorial: psychiatry should be taught from day one in medical school
*Nordic Journal of Psychiatry*, 72: S3-S4
https://doi.org/10.1080/08039488.2018.1525646

Access to the published version may require subscription.

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Trainee editorial: psychiatry should be taught from day one in medical school‡

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To cite this article: Louise Öhlund & Ingrid Lieber (2018) Trainee editorial: psychiatry should be taught from day one in medical school‡, Nordic Journal of Psychiatry, 72:sup1, S3-S4, DOI: 10.1080/08039488.2018.1525646

To link to this article: https://doi.org/10.1080/08039488.2018.1525646

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Published online: 07 Dec 2018.

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‘Help me doctor, I have nothing to return to. My family is dead. I will be tortured if I return to my home country. I do not want to commit suicide, but it will at least be a peaceful and dignified death.’

We had just finished our medical studies. Our training in psychiatry was sufficient for taking a proper psychiatric history, perform a mental state examination and diagnose the most common conditions. It is our first workplace as newly graduated physicians. The woman who’s looking at us is at least 30 years older than us. She is on her bare knees as she quivers and cries. She is stretching her arms towards the sky while asking God and us for help alternately. We are not prepared and feel completely inadequate.

‘To cure sometimes, to relieve often, to comfort always’ might strike a recognizable chord as a modernized simplified version of the two-thousand-year-old Hippocratic Oath. A more recent interpretation of doctoral duty is the World Medical Association’s declaration of Geneva ‘physician’s pledge’, wherein the health and well-being of our patients will be our first consideration [1]. But then again what does health and well-being mean to our patients?

During early training, we learn that our primary medical role is to diagnose and treat a patient’s disease by prescribing medication to relieve certain bodily symptoms. We rarely think about the person who is experiencing the illness and how her/his condition affects mental state and functioning in daily life. We are trained to separate panic disorder from unstable angina, functional spasm from epilepsy, sending patients home with a blatant message that their condition is not as harmful as any strict somatic disease. Separating body and mind this way, we pull apart what belongs together. Our risk to miss potentially severe mental illnesses also increases.

In Sweden, psychiatric diagnoses account for the highest burden of illness in both men and women with high incidence and long duration. In 2016, 45% of women and 32% of men working were on sick-leave due to psychiatric disorders. For unemployed, these figures rose to more than 50% for both men and women [2]. In face of this reality, it is concerning that medical schools only allocate a few weeks of psychiatric training during undergraduate medical training.

During this masterclass in transcultural psychiatry, Professor Dinesh Bhugra argued that ‘Psychiatric training should already start from day one of medical school’ [3]. We salute this idea and contend that psychiatry integrated early during medical training is essential to learn to treat an illness in a way that includes the whole person. That way, the medical practitioners’ responsibility would not be defined by and limited to organ dysfunction, specific symptoms or test results, but to the wellbeing of the whole individual. Considering body and mind as one would honor the increasing evidence that physical health affects mental health and vice versa [4–6]. Depression, for example, is a common secondary outcome after a myocardial infarction. But depression is also an important independent risk factor for the progression of cardiovascular disease [6].

Another important issue raised by Professor Bhugra concerned the terms of ‘disease’ and ‘illness’. Whereas physicians diagnose and treat diseases, patients suffer from illness in the context of loss of social functioning [3]. As our agendas may differ, we need strategies to understand patients’ interpretation of their illness.

In addition, we learned that understanding mental disorders is not possible without understanding cultural differences. In our daily practice, we should be attentive that prominent features of common psychiatric disorders will vary in different ethno-cultural settings [7]. Ethnic differences might have a great impact on received diagnoses [8]. Considering culture and adapting intervention accordingly improves response [9].

During the masterclass, several strategies were presented that might help us, medical interns and prospective psychiatrists, to improve our consultation skills in transcultural settings. Shared decision-making, based on the principle that patients share the responsibility for health care decisions in agreement with their doctors, fosters autonomy and self-determination of the patients entrusted in our care [10]. ‘An interpretation of an interpretation’, relates to Kleinman’s vigorous statement that patients interpret their symptoms based upon their own cultural settings. In clinical consultations, physicians should convey how they perceive the patient’s own interpretation [11]. Finally, the ‘Cultural Formulation Interview’, is a person-centered DSM-5 based interview tool that can help us systematically to assess cultural factors during consultation [12,13].

The woman with deportation order will forever be stuck in our memories. She is a reminder of that there will be many situations during our work life where skilled communication, knowledge in pathophysiology and drugs cannot ‘fix’ a human. We must accept that ‘there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon’s knife or the chemist’s drug’ [14]. Values concerning the well-being of the patient as an individual and as an entity are important in medical training as well as in everyday clinical practice. Transcultural psychiatry is one way to ensure that such values keep gaining ground, improving psychiatry as a whole.

‡4th masterclass psychiatry: transcultural psychiatry – diagnostics and treatment, Luleå Sweden, 22–23 February 2018
Disclosure statement

No potential conflict of interest was reported by the authors.

References


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