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Psychiatry Encompasses Much More Than Clinical Neuroscience

To the Editor: We commend the efforts of Reynolds and colleagues¹ to achieve “the reintegration of undergraduate and graduate medical education in psychiatry and neurology under the rubric of clinical neuroscience.” As supervisors and teachers of psychiatry residents, we also agree with those authors that “psychiatry is grounded in clinical neuroscience” and that our residents need a “deeper understanding of genetics, pathophysiology, functional neuroanatomy and neuropsychopharmacology.”

However, we believe psychiatry is grounded in much more than clinical neuroscience, and that Reynolds and colleagues have given short shrift to the philosophical, social, psychological, and humanistic foundations of psychiatry. Indeed, though we proceed from different premises than do Healy and Mangin,² we agree with their comment that psychiatry “need[s] more, rather than less, philosophy and psychology within the discipline.”

One of us (R.P.) has coined the term *encephiatrics* to encompass a broad-based, pluralistic discipline that incorporates not only the clinical neurosciences but also elements of philosophy, literature, and the world’s spiritual traditions.³ We do not regard these substantive disciplines as mere elective “frills” in psychiatric education; rather, we believe that residents in psychiatry should be exposed to the humanities and social sciences as an integral and required part of their training. Indeed, the psychiatry residency program at SUNY Upstate Medical University is now developing a “humanities track” for residents who wish to concentrate their studies in this area. We also believe that fostering competency in providing cognitive-behavioral, interpersonal, psychodynamic, and other forms of “talk therapy” must remain a central focus in a resident’s education, so that all aspects of a patient’s illness may be addressed comprehensively and compassionately. In our view, these points were not

adequately stressed by Reynolds and colleagues.

Ghaemi⁴ argued that the pluralism of psychiatrist and philosopher Karl Jaspers “has still failed to be adequately appreciated by the psychiatric profession.” We fully agree. To put it in clinical terms, “The clinician who can instantiate the neurobiology of serotonin in the context of the existential dilemma of the patient . . . has a far better chance of preventing suicide than one who is entrapped in a solitary paradigm.”⁵

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Choosing IMGs for Residencies: What Are the Factors?

To the Editor: The recent paper by Green et al¹ reporting the results of their survey of U.S. residency program directors is a comprehensive overview of the criteria applied to U.S. medical school graduates (USMGs) in determining selection for residency positions. We commend the authors for this work.

However, each year, one fourth of the residents entering GME programs accredited by the Accreditation Council for Graduate Medical Education are international medical graduates (IMGs), yet they were not represented in this study. Before entering GME, IMGs must achieve

certification from the Educational Commission for Foreign Medical Graduates (ECFMG), and certification is predicated upon passage of the United States Medical Licensing Examination (USMLE) Step 1, Step 2 CK, and Step 2 CS and primary source verification of their medical diplomas and medical school transcripts. The factors that may influence program directors’ selection of qualified IMGs are similar to those of USMGs with regard to performance on the USMLE but differ in other ways. For example, spoken English proficiency, which is measured in Step 2 CS, visa status, and prior GME training, may be taken into account by program directors. There may well be other factors that are evaluated prior to selection of an IMG for a residency position.

A survey of similar scope was conducted by the National Resident Matching Program in 2008.² Although that survey was more granular than the one by Green et al with the exception of visa issues, it also did not address factors relevant specifically to IMGs. (Perhaps the most interesting contrast in the two surveys was a disparate rating reported for the Medical Student Performance Evaluation.)

There would be a great deal of value to IMG applicants as well as to program directors if data and information were available on the relative importance of components of the application package that are unique to IMG applicants. Either revised surveys including these elements or a focused survey are called for to see whether there are significant factors at play for program directors’ selection of IMGs into residency positions.

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program directors survey. *Acad Med.* 2009;84:362–367.

- 2 National Resident Matching Program. Results of the 2008 Program Director Survey. Available at: (www.nrmp.org/data). Accessed June 10, 2009.

In Reply: We appreciate the comments by Drs. Whelan and Hallock. In the letters and e-mails that asked for participation in our survey, there were no directions given to program directors regarding whom to include or exclude in terms of applicants to their residency programs. While it is true that there were no specific questions that would have targeted issues related to IMGs, their applications do contain many of the same data (USMLE scores, grades, clerkship narratives, class rank, etc.) that are depicted in Table 3 in our report. It is possible that when answering the questions, program directors included *all* residency applicants when the questions allowed for that. Therefore, we cannot agree with the statement by Drs. Whelan and Hallock that “they [IMGs] were not represented in this study.”

We agree with Drs. Whelan and Hallock that a subsequent study that specifically addresses IMG applications would be useful. We do plan to include some specific questions related to this issue on a subsequent survey.

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Seeking Common Ground Between Medical Humanities and Basic Sciences

To the Editor: Shapiro and colleagues¹ note that “[i]n medical education, the current process of socialization encourages a reliance on insiders (physicians) and distrust of outsiders (nonphysicians)” that undermines the credibility of medical humanities teachers. This

“trustworthiness critique” can incorporate another significant component: Learners also view basic science faculty as “insiders.” Students’ extensive prior experience with such faculty and their disciplines contributes to this perception. Institutional structures and pedagogical styles reinforce the perceived “foundational expertise” of these teachers in contrast to medical humanities instructors. This identification of basic science faculty as “insiders” is especially strong during the first two years of medical school; even students following nontraditional curricula must pass Step 1. And it is likely more pronounced at community-based medical schools, where physician faculty are more dispersed.

Recognizing the level to which medical students view basic science faculty as “insiders” extends two of Shapiro and colleagues’ recommendations. First, it complicates the process of seeking the “buy-in” necessary to move medical humanities out of the margins. The “underlying commonality of interest uniting medical humanities and medicine” such as “increased personal and professional awareness and self-critique” provides common ground on which to build support and collaboration with clinical faculty. Such goals, however, are not as compelling for basic science faculty. At worst, basic scientists react negatively to the subjective, critical focus of medical humanities pedagogy—or are indifferent or unaware. At best, basic science faculty respect the goals shared by medical humanities and clinical faculty in the areas of personal and professional development, but view them as distinct from their own curricular objectives centered on content acquisition. Both responses position medical humanities at the periphery of medical education.

Second, the perception of basic science faculty as “insiders” locates them as student role models, especially during the first years of medical school. Their attitudes toward medical humanities education get transmitted to learners implicitly and explicitly. Therefore, humanities educators need to seek ways to help not just “interested physicians become more effective in manifesting humanistic skills and values in their teaching,” but

also basic scientists. The challenge for content-based lecturing is clear. Problem-based learning, though, presents a significant challenge as well in its emphasis on a narrative in which the detective (teacher/learner) follows the clues to solve the case or successfully diagnose the patient by mastering the underlying science. The lack of common ground noted above further increases the challenge.

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In Reply: Dr. Koepke makes valuable points: that basic science faculty’s often uninterested and even unsympathetic attitudes toward the medical humanities further complicate the already challenging task of establishing “common ground” between clinicians and humanities scholars, and that, during the initial two years of medical school, basic scientists serve as students’ primary role models. In our experience, although medical students (rightfully) respect achievement in biological science and, in this sense, “look up to” basic science faculty, most first- and second-year students see the *clinical* faculty whom they encounter—more now, fortunately, than in the past—as their more substantial role models. That having been said, basic science lecturers do exert substantial influence on students in terms of the attitudes and behaviors demonstrated in the classroom. This influence is compounded at schools where the basic science faculty exercise virtual control over the first two years of the curriculum, creating the perception of prestigious “insider” status. Even in so-called integrated curricula, humanities scholars do not begin to approximate this level of legitimacy.

Regarding the certitude with which many of our basic science colleagues rely on the logico-scientific perspective (what they might term Truth), we agree that this stance makes meaningful

intellectual exchange difficult at times. Here, the fable of the blind men feeling the elephant comes to mind. The point of that classic tale is that the sum is necessarily greater than its parts. This would seem to be especially true about the complex art and science of doctoring. No one, not scientist, not humanist, not even clinician, possesses enough "truth" to fully encompass the intricacies involved when one person tries to heal another. As Koepke astutely notes, the most pressing concern is that, in the medical education hierarchy, certain voices are prioritized over others. In the first two years of medical education, these dominant voices often belong to basic scientists. In the last two years, the clinicians hold sway, especially those from high-status specialties. The humanists, alas, remain mostly on the sidelines.

When ideas, perspectives, and values can fairly compete in the intellectual and affective marketplace, we have confidence that challenges from basic science colleagues can only enrich the dialogue about how to better teach future physicians. But when humanities scholars must engage in such conversations not only within the context of a shared blindness but with a piece of tape over their mouths, then the disadvantages confronting the humanities will never be overcome.

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Medical Education Under Economic Sanctions in Iran

To the Editor: Medical education in Iran is a sturdy phenomenon. Despite the eight-year war with Iraq, 30 years of U.S. sanctions, three United Nations economic sanctions, and consequent reduced government budgets for public spending, Iranian medical educators have not been disheartened from undertaking training programs in a wide variety of medical specialties.

The number of medical schools has increased from 13 in 1979 (before the 1979 revolution) to 48 today, representing approximately one school for every 1.5 million people. Iran has been ranked ninth out of 235 countries in terms of the number of medical schools.¹ Study in state universities is free. The basic medical education course lasts seven years. Curricula are mostly based on a post-Flexnerian doctrine, in which basic sciences are taught before clinical sciences. In 2007, Graduate Entry to Medicine was established in the Tehran University of Medical Science for the first time. (This means that graduates from university programs besides basic sciences programs, such as biology, can apply for medical school.) Currently, 25 specialty and 20 subspecialty training programs are offered. Furthermore, 39 PhD basic science programs, including medical

nanotechnology, have been launched in Iranian universities of medical sciences. There is a highly competitive national examination for entering these programs.

However, the qualitative and quantitative growth of medical education have not been parallel. The quality of medical education in Iran still needs much development in several areas, including the standardization of curricula to provide consistently high-quality health care; improvements in pedagogic practice, assessment systems, and student selection; and more emphasis on patient-oriented care, international collaborations, faculty development programs, medical education research, and research funding.

Until now, little has been accomplished in those areas. There is a need for medical educational leaders with inspirational qualities to foster the development of better medical education programs.² But even if such leaders emerge, progress in Iran's contribution to the quality of global medical education will probably be limited until sanctions are removed.

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