Psychiatric Education: Thinking Skills for Trainee Psychiatrists

T. Maniam

Universiti Kebangsaan Malaysia Medical Centre, Cheras, Kuala Lumpur, Malaysia

The discipline of psychiatry requires the use of thinking skills to perform a number of tasks. The assessment of a patient’s history, his mental state especially the evaluation of thought disorders, the formulation of a diagnosis and differential diagnosis, the formulation of a management plan for what are often complex human problems and the wise application of therapeutic techniques, all require complex thinking skills. The process of communication with patients and their relatives is often fraught with pitfalls that requires a thoughtful approach that makes use of consciously shared information as well as non-verbal information. Evaluating scientific papers is another area that requires critical thinking. At times the lack of critical thinking is painfully apparent. It appears that schools, and sadly universities too, are merely training people and not educating them. Occasionally, of course, one is pleasantly surprised to come across a student with a very sharp and critical mind.

Arguably, the present school system does not appear to be training students to be critical. The emphasis seems to be on rote learning and deference to authoritative pronouncements rather than training students in analytical thinking. Furthermore the emphasis on academic excellence, narrowly defined as how many ‘A’s one obtains, does not encourage students to read anything other than their textbooks and lecture notes resulting in a very distressing lack of general knowledge. Not many read the newspapers and hence are not in touch with the things that affect patients daily. Many years ago after a junior therapist’s first visit the patient contacted the referring consultant and declined to see the therapist again. Why? “He doesn’t know anything!” The patient meant that the therapist had such poor general knowledge that she could not carry on a meaningful discussion of issues affecting her life. And such thinking persists into the university and on into postgraduate training even after 5 or 6 years of medical school. One wonders, with Asher¹, how “such travesty of thinking survived the rigours of a scientific education.” Errors of logic are a major problem with most trainees. Most appear to have had little training in thinking skills, nor seem to be aware of the rules of logic. Few have heard of deductive thinking or syllogism. Many have never heard of Karl Popper’s comments on science and pseudoscience². Fewer still read good novels that express human thoughts and emotions with greater clarity than psychiatric textbooks. In this article I would like to highlight some of the common thinking and logical errors I have seen and conclude by raising questions about how these may be rectified.
Excessive deference to the views of those in authority

There is a common tendency among psychiatric trainees and perhaps among university students in general, not to question the views of their teachers, even when they are certain that those views are clearly erroneous. This could be for a number of reasons, among which is fear of reprisal or of being victimised for showing up the errors of their teachers. This is an attitude that is sometimes fostered in their earlier school days. One student shared that when she privately pointed out her teacher’s mistake at school, the teacher’s response in settling the issue was: “Are you older, or am I older?” It is as if the correctness of an answer, indeed truth itself, is determined by the age of the speaker! It is sad that the teacher did not see how damaging, and absurd, her statement was. Another student got a public scolding for pointing out an error in his teacher’s statement. Both these students stopped asking questions in their classes after these incidents. Are we teachers and lecturers so lacking in self-esteem that any correction is an unacceptable blow to our self-image? I must admit that in my earlier years I have had difficulties in this area myself.

This deference to authority sometimes leads to an illegitimate appeal to authority. For example, trainees at times say “Professor So-and-so said this.” But a moment’s reflection tells us that if Professor A is an authority in psychopharmacology, but not on psychodynamic psychotherapy, his views on psychotherapy cannot be taken as being authoritative. This is an error committed by not only trainees but specialists as well. One often hears experts in one field pontificating in other areas in which they have absolutely no expertise.

Deference to authority is compounded by students’ own lack self-confidence, either in their grasp of the subject or the ability to engage in a discussion in the English language. This leads to many a quiet class.

Simplistic explanations

This is a common error among medical students and psychiatric residents. An explanation by a patient is accepted as the true explanation, without evaluating whether it is really so. One trainee reported, “The patient attempted suicide because his religious belief was not strong enough.” This is an example of a naïve, and thoughtless conclusion that some trainees often offer, not much different from laymen’s reasoning. The complexities of the causes of suicidal behaviour have been reduced to a single, unsupported statement, which may or may not be a contributory factor.

Accepting statements at face value

Patients’ explanations and attributions may sometimes be correct, but often they are incomplete and misleading. A patient says he lost his job because his boss was vindictive, and the trainee stops exploring for other underlying causes. Did the patient contribute in any way to his superior’s displeasure? Was the patient already ill before he was dismissed?

Committing other logical fallacies

A few other examples of logical fallacies that I have picked up follow:
Argumentum verbosium – proof by verbosity. The speaker talks so much it is assumed what he says must be true.

Post hoc ergo propter hoc – literally meaning ‘after the event therefore because of it’. If event B occurs after event A, it does not necessarily mean that event B was caused by event A. To give an example, albeit a ludicrous one, if the sun rises after the rooster crows, it does not mean that the crowing of the rooster causes the sun to rise. Association or correlation does not necessarily imply causation.

Ecological fallacy – inferences from group or population studies are uncritically applied to the individual. For e.g. a study shows that 75% of patients do well when prescribed medication within a dose range, therefore, it is erroneously concluded, there is no reason why any patient should have lower or higher doses. This is often committed by those who appeal to mean data in published works, while ignoring the fact that each individual is unique and that there is no such thing as an average patient. However large the studies “it is its effect on my patient that matters”, says Seaton\(^3\) in a personal opinion with a catchy title, “There’s none so blind as the double blind.”

Appeal to motive – where a statement is dismissed by questioning the motive of the speaker. We may unfairly dismiss the findings of a researcher because he was sponsored by an interested party, though it is good to be critical and not accept things at face value.

Appeal to tradition – where an assertion is accepted as being correct because that is the long-established traditional view. Very often we fail to, or dare not, consider changes because of the deference to tradition, without examining its truth value. If our psychiatric forefathers had not challenged tradition we might still be treating schizophrenia with hydrotherapy. As Seaton’ said, perhaps rhetorically, “All progress depends on the sceptic.”

Conclusion

There are many more areas and examples one could cover. We need to seriously think about what essential reading we set for our candidates. Just reading a Wikipedia entry on logical thinking might be helpful\(^4\). The critical review paper that candidates sit for in the Part II examinations appears to focus more on statistical thinking rather than on general rules of logical reasoning. Should an introductory course in logic be required in the curriculum? If so, when and how? Are trainees already overburdened with reading material? Would it be better to allocate one journal discussion a month solely to issues relating to logical thinking? How do we encourage candidates to read the newspapers or news analyses? Perhaps undergraduate medical training needs to be thought through as well. I invite, if the editor permits, critical comments on these suggestions.

References

3. Seaton A. “There’s none so blind as the double blind. Discuss.” BMJ 2003; 326: 889


Corresponding Author:
Professor T. Maniam
National Advisor
Editorial Board Malaysian Journal of Psychiatry

Email: tmaniam@yahoo.com