Title: “Soft and Fluffy”: Medical students’ attitudes toward psychology in medical education
Abstract

Psychology is viewed by medical students in a negative light. In order to understand this phenomenon we interviewed nineteen medical students about their experiences of psychology in medical education. Interviews were transcribed verbatim and analysed using thematic analysis. Four main themes were generated: attitudes, teaching culture, curriculum factors, and future career path; negative attitudes were transmitted by teachers to students and psychology was associated with a students opting for a career in general practice. In summary, appreciation of psychology in medical education will only happen if all educators involved in medical education value and respect each others speciality and expertise.

Keywords: Attitudes; behavioural and social science; graduate entry students; psychology
Introduction

One way that health psychologists improve patient and population health is through the teaching and training of other health professionals including nurses, physiotherapists and medical doctors. In fact, psychology is a core component of the behavioural and social science (BSS) component of the medical curriculum and is now commonplace in medical schools across the globe (World Federation for Medical Education and Europe 2007); the behavioural and social science curriculum includes psychology and sociology. Where sociologists are more inclined to teach medical students about the functional role that social institutions such as medicine play in socialising physicians, maintaining the well-being of society and how patients learn sick role behaviour, psychologists are more likely to teach medical students about the importance of how a person’s psychological make-up and experiences impact their health and illness and often focus on skill development (e.g., communication, adherence techniques).

Moreover, the importance of psychology to medical education is largely attributed to the fact that psychological, behavioural and social factors are key determinants and correlates of a range of health outcomes, including the prevention, onset, recovery and management of a range of illnesses (Behavioural & Social Sciences Teaching in Medicine Group (BeSST; 2009). It is also driven by a need for more patient-centred care and national medical councils making explicit the need for training ‘the doctors of tomorrow’ on these topics (BeSST, 2009). It must be noted however that other health professions are also affected. In fact a similar call for training dentists on psychological factors and dental care has also just been made (Diercke, Burger, Bermejo, Lux, & Brunner, 2012). However, health psychologists are ideally placed to teach on the medical curriculum as they have expertise in behaviour change techniques, health promotion, adherence, stress and illness management and other health psychology theories all of which are pertinent for improved patient and population health as well as health care delivery. Moreover, despite psychology being seen as a core component of medical education, it struggles alongside biomedical subjects, and is often not taken seriously by medical students (BeSST, 2009; Carr et al. 2007).

Teachers of psychology in medical education report barriers to effective teaching and learning (e.g., the suitability of teachers, curriculum space, biomedical mindset and staff attitudes)(Litva and Peters 2008). There are questions about the ideal as opposed to the core
psychology curriculum for medical students (Benbassat et al. 2003; Satterfield et al. 2010) and student resistance to or appreciation of this topic in medical education has been found (Benbassat 1996; Benbassat et al. 2003). This is perhaps complicated even more by the fact that these topics are not delivered by specialists and an ever changing medical and overcrowded curriculum (Peters & Litvia, 2006); small group problem-based learning models and early patient exposure are being advocated by governing bodies (Cooke, Irby, & O’Brien, 2010) and this raises new challenges for psychologists to adapt their teaching and learning methods in line with course content. Despite this however, medical students see psychology as being ‘nice to know’ as opposed to ‘need to know’ and it often competes with biomedicine (e.g. anatomy) for greater acceptance p. 20 (De Visser 2009). However, medical students in Poland and Russia rated psychology as an important topic (Jakušovaitė and Blaževičiene 2007), while other studies have found that early patient exposure facilitated greater appreciation of psychology (Littlewood et al. 2005; Benbassat et al. 2003). Nevertheless, doctors and medical residents who had poor psychosocial training during their initial medical education held more negative attitudes toward psychology and felt it was not really relevant to patient care, implying that this is perhaps a critical period for shaping student experiences of psychology (Astin et al. 2006). Moreover, some psychologists have even argued that there is a ‘hidden curriculum’ where psychology is only there for show and it is not really given the credit it deserves (De Visser 2009). In fact, because the current medical curriculum is often viewed as overcrowded, the addition of psychology as a core component may be viewed as threatening to other curricular content (Satterfield et al 2010); this threat may foster a ‘hidden curriculum’ whereby an unscripted and interpersonal form of teaching and learning takes place between and among faculty and students away from the guiding formal curriculum to influence physician’s behaviours (Bennett et al., 2004). Thus, taken together these studies suggest that there a variety of forces at play that may shape student thinking and behaviour. Despite this body of evidence, what is not yet known is how the early training environment shapes medical students’ attitudes toward psychology and to determine if there is a ‘hidden curriculum’ in operation in medical education. If medical educators can identify the factors in the early training environment that contribute to negative attitudes then it may be possible to target these factors through improved educational practices.

Moreover, if medical educators are committed to ensuring that the doctors of tomorrow have core training in psychological principles and methods then it is important that a
greater understanding of the pedagogical and contextual issues surrounding psychology in medical education is needed. In the present study we report on the attitudes and experiences of graduate entry medical students (GEMS) toward psychology in medical education who are attending a medical school in Ireland. Further, to date studies with medical students have used quantitative research (Jakušovaitė and Blaževičienė 2007), with a lack of qualitative studies evident. The advantage of qualitative methodology over quantitative research is its ability to provide complex textual descriptions of how people experience and interpret a given research issue which make it an ideal fit in this particular context.

Methods

Consideration of Context

The study was conducted in a 4-year graduate entry programme in the Republic of Ireland. The teaching model is problem-based learning (PBL). Each week PBL sessions are focused around a particular health condition which is usually explored from the biomedical, sociological, legal, psychological and patient perspective and facilitated by a medical tutor. The first two years of study are primarily academic; students also meet with two primary care patients as part of the early patient contact programme in these years. The psychology lectures are taught under the umbrella of Professional Competencies (which includes medical ethics, sociology, epidemiology and biostatistics) and are delivered by a health psychologist, from the Psychology Department. Sociologists deliver the sociology aspect and medical law expert delivers the medical ethics component. The psychology lectures are delivered over the first two years and their learning outcomes (LO) are linked and discussed at the PBL case study sessions. The topics covered (e.g., bereavement, mind-body medicine, behaviour change and personality) are in line with a recent report highlighting these topics as core areas to be covered by all medical students (BeSST, 2009). The final two years are spent on clinical rotation with academic teaching continuing both on and off campus (e.g., hospital-based) where psychology and other social science teaching is limited to communication skills training which are taught by other specialties. However, we should also point out that a clinical psychologist also delivers an elective Human Doctor module in the later years where medical students learn about managing stress in their own life.

Participants
An email was sent to all current students of the medical programme— including all cohorts inviting them to participate in this research. The email was distributed via the university’s (UL) online learning environment (Sulis) and via lectures and word of mouth. Nineteen GEMS student agreed to take part in the study. Of these, 10 were female and 9 were male. The age range was 23 to 42 years old, with an approximate mean age of 28 years. A breakdown of gender, age, previous degree by cohort for the sample is illustrated in Table 1. Each student gave informed consent and ethics was approved by the local University Research Ethics Committee and comply with the Declaration of Helsinki.

**Data Collection**

Single, face-to-face semi-structured interviews were undertaken with students from each cohort across the medical school from January to June 2012. All interviews were held in quiet rooms. The open-ended questions were developed through a review of the current literature on medical students experiences of psychology and BSS in medical curricula. The interview schedule was comprised of the following questions: (1) Psychology in medical education. What do you think about this? (2) What kind of things or experiences has shaped or informed your thinking regarding psychology in medical education? Prompt: Teaching/lectures/previous degree – expand a little - why and how? Early patient contact – why and how? (Prompt if not mentioned.) (3) In what way does psychology compare to other parts of the medical curriculum? Prompt: Same status/equal – why – expand. (4) In what way to do think psychology may help you in your career? Possible prompts: Patient satisfaction and understanding, psychology toolkit and behaviour change and adherence, own health. (5) Imagine an ideal world what kind of psychology training/teaching would you like to see put in place across the curriculum? (6) Is there anything else that we haven’t covered or that you would like to add before we’re finished? Interviews were on average 45 minutes in length. The length of the interview was determined by the time available for the participant to contribute. All the questions were asked in each interview. It is important to acknowledge that the interviews were carried out by the author (SW) who has background in both sociology and psychology; both SW and SG (a health psychologist) were involved in designing the interview schedule, conducting the data analysis and interpretation; however, every effort was made to minimise any potential biases that these positions may have brought to the data analyses through consultation with co-author (DM).
and other psychology colleagues not involved with the project. However, it is possible that interrogation of the data from a different perspective may yield different results.

**Data Analysis**

The interviews were audio recorded and transcribed verbatim by the researcher who had carried out the interviews. The researcher adopted an inductive bottom-up, thematic analysis approach for this study (Braun and Clarke 2006). This allowed for the themes to be constructed and to come from the data reviewed rather than from a preconceived theoretical position. The researcher also kept reflective notes throughout the process in order to be aware of any effect of researcher bias. In choosing a thematic analysis approach for this study, the interview data (transcripts) were read then re-read and coded line by line. These codes which represented recurring ideas were categorised into recurring themes and subthemes. Moreover, each transcript was revisited to trace any pertinent ideas or data (Braun and Clarke, 2006). The researcher remained very close to the data as part of the inductive, bottom-up approach. This approach worked well for the analysis of data and the essentialist method that was adopted. In thematic analysis, the essentialist approach "reports experiences, meanings and the reality of participants" (Braun & Clarke, 2006, p. 81). In order to provide a check on the validity of the analysis and interpretation of participants’ accounts, the authors SG and SW subjected the data set to further scrutiny by re-reading the transcripts and reassessing the themes. Direct quotations were then identified from the transcripts which illustrated each theme.

**Results**

Thematic analysis of interviews resulted in four main themes that influenced student perceptions and experiences of psychology in medical education with a number of interrelated sub-themes also identified. These along with supporting quotations are presented in text as well as in Table 2. In brief general attitudes were influenced by perceived status of psychology, teaching culture, curriculum factors and future career choice.

[Insert Table 2 about here]
Attitudes

Positive For some GEMS students’ psychology was seen as an important topic in the medical curriculum; one student said ‘It’s always interesting, human behaviour is interesting to me’ (Participant 16). On reflection, they appreciated the value of what psychology brought to medicine and felt that it would not be on the programme if it wasn’t important, while another said ‘in hindsight I do, you can see it now’ (Participant 17). However, these positive attitudes were not evident among all those interviewed.

Negative

Other students interviewed discussed how they perceived psychology as an additional subject. They talked about it being ‘supplementary’ and ‘soft and fluffy’ compared to the other subjects on the programme, suggesting that psychology is seen as not scientific and as a peripheral subject, suggesting that it was ‘up in the air’ (Participant 9), ‘waffley’ (Participant 13), and ‘airy fairy’ (Participant 18). In fact, one student was confident in saying that most of his peers would see psychology as a misnomer subject and that they tended to trivialise it, ‘they just completely ignore it’ (Participant 16). This negative view of psychology is rather concerning given its core standing in the curriculum and studies showing that the initial training environment is seen as shaping these opinions (Astin et al. 2006). Further, more interesting is that these attitudes were shaped by the themes discussed below.

Perceived status of psychology

Psychology was seen as struggling alongside the other subjects within the curriculum to be considered as important. For example, a number of students spoke about how psychology was not scientific enough and ranked it lower in status compared to other biomedical subjects. Moreover, the consequences of this were that they devoted less time to it relative to the ‘hard sciences’, others said ‘they blow off anything that’s not science or easy to test because they think that they can just make something up’ (Participant 4). Psychology was seen as ‘the softer side of things’ (Participant 19); ‘there is not a lot of hard and fast
evidence’ (Participant 9). Further, the teaching environment that these GEMS students were exposed to seemed to shape their thinking around this perceived status much to the detriment of psychology.

**Teaching Culture**

*Teaching Ethos*

A biopsychosocial teaching ethos was strongly advocated and was acknowledged as shaping student thinking. Students mentioned that ‘We’re taught we’re kind of challenged to think about the bigger picture’ (Participant 15) ‘not just about pills but everything...understand them as a person’ (Participant 4). Students felt that this model was *hammered home* to them; however, they talked about how it may be only appropriate to some medical specialities. For example, clear links were made between psychology and psychiatry but not surgery or illness management etc. This was very surprising given that the students would have received lectures/sessions on all of these topics with explicit links made to the role of psychology in understanding these issues.

*Teaching Staff*

A key determinate of students attitudes were faculty staff, in particular teachers in PBL sessions. The message being transmitted by some teaching staff is that psychology is not as important as the other biomedical subjects; one student went on to say ‘The psychology is played down by—in my opinion it was more played down by the s—the actual faculty and that transferred on to the students and then to further play that down we weren’t tested on it’ (Participant 15). In fact, students were quite clear that mixed messages were being given, and given the negative attitudes toward psychology, it is evident which message source is more dominant. On the one hand students are being told that psychology is essential, i.e., lectures and school ethos, while on the other hand they are being informed, by teaching staff, that it is not relevant; the message being transmitted in this instance is that psychology, even if the students want to discuss it, is a topic they should *do in their own time* and not in PBL sessions. Moreover, PBL is the main teaching model advocated in the school and it is the only place where psychology LO’s are formatively assessed and this
is not happening. This suggests that a hidden biomedical curriculum may be at play here and is being driven by some medical faculty who have their own agenda which is not psychology. Thus, it is hardly surprising that as a subject it is being trivialised by students.

**Curriculum Factors**

**Content and Delivery**

Students talked about how the current teaching of psychology was too theoretical and not applicable to medicine. For these students examples of how psychological theories could be applied to the medical context would have been more beneficial or teaching them how to apply the theory in practice. Students in the clinical years of training wished for more psychology in particular to self-care and dealing with work-related pressures, implying that perhaps vertical integration is needed. Other students felt the way psychology was currently being delivered to them via lectures was less than ideal and suggested that the PBL format would work better. However, this finding further strengthens the notion that a hidden curriculum operates on the ground with students not realising that the PBL sessions are where the actual psychology LO’s are to be formatively assessed via discussion; this is illustrated by the following quote ‘different tutors who treated them(LOs) less—as a lesser, of lesser importance than others but not all of them’ (Participant 14). The lectures are to inform the students about the importance of psychology to understanding the case study being discussed in the PBL session.

**Assessment**

A related issue was the method of assessment used for psychology. Students discussed how they wanted the essay component changed and replaced with something more relevant to their learning; suggested replacements were mini projects or diaries. Although others thought that by using an exam format to assess psychology would increase the importance attached to it. In fact, these students suggested that it would be taken a lot more seriously by students if it was assessed in an exam; ‘They put the lectures there and they say that it’s important but like you can say all these things but if you don’t actually test us on it’
Thus, it seems that how psychology is assessed shapes students attitudes toward psychology.

**Early Patient Contact**

Despite studies showing that early patient contact had a positive effect on attitudes toward psychology, (Littlewood et al. 2005; Benbassat et al. 2003) this was not readily apparent here. Although some felt that it was a good idea to get them to reflect on the actual patient experiences rather than on the assessment, the purpose and relevancy of the early patient contact programme was lost on some students. For these students it depended on the actual patients that they were exposed to ‘I happened to have two really, really positive experiences’ (Participant 14), and they felt it was a rather personal experience and they failed to see the benefit of it, ‘we didn’t really focus on psychology or anything like that’ (Participant 12). Thus, in lieu of these findings it suggests that the early patient contact programme for psychology at least is a little bit more nuanced than originally thought and perhaps further exploratory work on this area is needed.

**Course Workload**

The amount of work on the course overall was also seen as somewhat prohibitive for engaging with and appreciating psychology. Students discussed that they do not have space for it with some preferring not to attend psychology lectures as they had to prioritise their workload, and psychology was not a priority. One student said ‘I just have so much on my plate trying to learn the basics that it kind of gets pushed to the side’ (Participant 12). An overcrowded curriculum has been noted in previous research as a barrier to integration of psychology (Litva and Peters 2008). Here however we have found that students are making space and taking the time for more important subjects in particular those which are continuously assessed.

**Future Career Choice**
Interestingly students also made reference to psychology being associated with a career in general practice (GP). A divide was noted between the choice of a career in general practice and aspirations to become medical consultants and the perceived importance of psychology; ‘Some people look down on GP for example. There’s a stat—there’s a status issue with everything within medicine. So you have the people at the very top that might be the surgeons, who look down on medicine. Medicine look down on general practice and general practitioners just feel like—nobody’ (Participant 19). Students also suggested that GPs are seen as ‘huggy wuggy, like psychology ’soft and fluffy’ and consider GP the poor relation in specialist medicine. Further, what was also interesting was students discussed that how GPs attach importance to talking to the patient and getting to know the patient to gain a greater understanding of their needs whereas consultants in the hospital regard the patient as someone who does not need to be listened to just medicated and treated. However, when one considers that a doctor-centric approach to patient care is seen as outdated and not conducive to quality patient care, (Epstein and Street 2011, Committee on Quality of Health Care in America, 2001), it again raises the issue of how influential the early training environment is. Moreover, it also suggests that students are receiving mixed messages about psychology from a variety of sources across multiple contexts.

Discussion

Perceptions of psychology in medical education amongst GEMS students were somewhat mixed. Although attitudes toward psychology were positive in general, students did hold negative attitudes and these views were largely driven by factors within the training and learning environment. What is novel about our study is that is not the students per se or their beliefs that hinders the successful integration of psychology into the medical curriculum but factors amenable to change at a programme level. Consistent with other research in the area, (Benbassat et al. 2003; Litva and Peters 2008), what came across quite clearly is that psychology as a discipline continues to struggle for space and acceptance against the biomedical sciences in the medical curriculum. Furthermore, when one considers the literature as a whole, including our study findings, this pattern is seen irrespective of whether it is graduate entry or non-graduate entry; thus negative attitudes are not explained by prior learning experiences of or medical students. Moreover, PBL appears, in its current format at least, to not offer any advantage over traditional teaching
methods in this regard. Additionally, those in the clinical years would have wished for more psychology in the area of dealing with stress and coping, indicating that perhaps a vertical integration is more suitable and the topics delivered may need to match student needs or stages of learning.

In the UK, issues of time and space, and an underlying biomedical mindset and hidden curriculum were seen as barriers to integration (Litva and Peters 2008). In the present study we found similar results (e.g. high workload, low status subject) and in particular the teaching environment associated with teaching culture and staff attitudes to be influential in shaping attitudes and perceived status of psychology among these medical students. Despite the biopsychosocial model being advocated at the programme level, in reality what we found was that the model was not always applied, especially during the PBL sessions where the psychology lecture LOs are meant to be formatively assessed; here the message being transmitted to students by some tutors, though not all, is that psychology is something that is ‘nice to know’ rather than ‘necessary to know’, supporting the ideas of others (De Visser 2009; Satterfield et al. 2010). As a consequence, psychology is perceived as a low status subject; attendance at psychology lectures is poor and students do not devote as much time to learning about psychology or show as much interest in it relative to biomedicine. Perhaps this is suggestive of the “hidden curriculum” (Adler, 2009), seen elsewhere that sees biomedicine as true knowledge and a pure, hard science (Michalec, 2012). Moreover, transmission of such attitudes to young impressionable medical students by more experienced staff has been found noted elsewhere (Mattick and Knight, 2007). However, it could also be that formative assessments during PBL sessions are less than ideal and perhaps more summative assessments on psychology are what are really needed to change perceptions of psychology. In fact, some students talked about what was the point in studying psychology if it was not going to come up in the exams.

The theme of curriculum factors, in particular the need for relevance to medicine appears to verify the findings of others (Litva and Peters 2008; BeSST, 2009); not making psychology relevant to medical training and practice was found to be a key barrier to the implementation of BSS in medical education. Further, the BeSST report noted that medical students do not need to know theories but that they have enough knowledge to inform practice and decision making (p.23)(BeSST, 2009). Thus, the call for more practical and less theoretical approaches to psychology in medicine seems appropriate and justified for the advancement of psychology within medical education. However, our own
School’s endeavours to address this issue through the use of PBL sessions, early patient contact, and interactive lectures needs to be revisited in light of these findings. The suggestion of using alternative formats for assessment including a mini-diary as a format for assessment is also warranted, and more use of non-traditional assessments has been highlighted as a means of improving greater appreciation (Epstein, 2007). Elsewhere, the use of novels to teach medical students about health psychology topics has been found to be very effective (Kaptein and Lyons, 2009). Further, the use of a workshop on the early patient contact programme to explore psychological issues would be an interesting way of assessing students’ understanding of their psychology; this option, along with reflective diaries, is currently being put into operation in our school and together they may facilitate making psychology more relevant to medicine and shaping more positive attitudes.

The idea of the future career path as being a factor in students’ perceptions of psychology was new to the researcher. Although other studies have found that medical students (Jakušovaitė and Blaževičienė 2007) (Russian and Polish) felt that psychology would help benefit them in their future careers, we found that this benefit was perceived as being only useful for some specialities. Students perceived general practitioners (GP) to be, unscientific, like psychology and huggy wuggy whereas biomedicine (anatomy, physiology) was truly scientific; the effect of this was that general practice was seen as lower status speciality. This idea of a medical hierarchy is not new and has been seen elsewhere (Philbin et al. 1999). What is interesting however is that these perceptions toward psychology and career speciality appear to begin in the early training environment through exposure to teaching mentors; a finding noted by others (Littlewood et al., 2005; Taggart, Wartman & Wessen, 1987). However, what was pertinent in the findings here is that consultants were adopting a doctor-centred approach to care and advocating its use to students. This raises a serious concern for medical educators who are trying to bring about evidence-based practice and move toward patient-centred care that these efforts are being undone by poorly trained teachers and mentors who should know better. Moreover, it also undermines the role of psychology, which places the patient at the centre, in medical education.

The limitations of the current study must be acknowledged. First, there were a small number of participants interviewed from year three compared to the other years. Some participants may not have been as forthcoming with their thoughts as the interview researcher was familiar with the psychology lecturer who taught in the medical school. The
researchers have strong social and health psychology backgrounds and this influence should be noted as it may have played a part in the analysis. Generalisation to the rest of the specific student population may not be applicable but these insights into students’ perceptions of psychology in medical education are useful to GEMS.

In conclusion, in order to ensure that the doctors of tomorrow are well equipped to manage the demands of the evolving health care system, we must ensure that they are in receipt of the best training possible to fulfil their roles. Despite changes to the medical curriculum psychology still struggles to be accepted as a legitimate subject within it. Further, there appears to be a hidden curriculum that is in operation in the critical early years that is shaping how psychology is viewed by students that needs to be challenged. Moreover, given that existing medical curricula are often viewed as overcrowded already, competition for curriculum space on 4-year graduate entry medical programmes creates greater challenges (Cullen et al. 2007). Moreover, assessment of psychology components within medical training may also need to be addressed to help alter the perception of its lack of importance perhaps by using more contemporary methods. Finally, to respond to this challenge it is the responsibility of all medical educators, not just psychologists, to appreciate and respect the value and contribution of each discipline and sub-speciality to medical education.

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**Conflicts of interest:** none
References


De Visser R (2009) Psychology in medical curricula: “need to know” or “nice to know”?


Table 1. Medical Students Characteristics by cohort

<table>
<thead>
<tr>
<th>Participants</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
</tr>
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<tr>
<td>Mean Age (Years)</td>
<td>25.8</td>
<td>27</td>
<td>35</td>
<td>31.3</td>
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<tr>
<td>Gender</td>
<td>Male</td>
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<td>2</td>
</tr>
<tr>
<td></td>
<td>Female</td>
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<td>5</td>
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<tr>
<td>Previous* Degree</td>
<td>Science</td>
<td>3</td>
<td>7*</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Arts</td>
<td>2</td>
<td>2</td>
<td>1</td>
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</tbody>
</table>

*One Student from Year 2 had previous degrees in both science and arts.*
<table>
<thead>
<tr>
<th>Themes</th>
<th>Subthemes</th>
<th>Sample Quotes (participant number in brackets)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Attitudes</strong></td>
<td><strong>Positive attitudes</strong></td>
<td>“very inspiring and very hopeful” (6); “It wouldn’t be on our course if it wasn’t important” (12)</td>
</tr>
<tr>
<td><strong>Negative attitudes</strong></td>
<td></td>
<td>“Supplementary (1, 3)”; “connotations of being soft and fluffy” (17); “Most of the students in my class would trivialise psychology” (9)</td>
</tr>
<tr>
<td><strong>Perceived Status of Psychology</strong></td>
<td></td>
<td>“I don’t think the psychology plays as big a role as others like the anatomy or PBL” (1); “it’s not factual enough….medicine is very scientific” (11).</td>
</tr>
<tr>
<td><strong>Teaching Culture</strong></td>
<td><strong>Teaching ethos</strong></td>
<td>“A lot of problems are not anatomical based they are driven by psychology” (5); “The school has really always hammered home this holistic model of care and then when it came to psychiatry and psychology that was really brought across and it makes sense” (18).</td>
</tr>
<tr>
<td><strong>Teaching staff</strong></td>
<td></td>
<td>“some of them are just with the students oh like this is stupid you don’t have to learn this or skip this or read this in your own time and some of them want to talk about it so it’s very very—it’s not consistent among PBL tutors” (16).</td>
</tr>
<tr>
<td><strong>Curriculum Factors</strong></td>
<td><strong>Content and Delivery</strong></td>
<td>“We need real life examples…, useful… applicable to medicine” (1); “relevance of psychology in practice, not education but practice” (10); “Case-based similar to the way PBL is done” (9).</td>
</tr>
<tr>
<td><strong>Assessment</strong></td>
<td></td>
<td>“Essay is useless” (9, 10, 11); “a mini project or diary of health behaviours (11); “Everyone would take (Exams) a lot more seriously (13).</td>
</tr>
<tr>
<td><strong>Early Patient Contact</strong></td>
<td></td>
<td>“it’s a good idea, but not ideal” (2); forces me to reflect more on that—I think that’s the whole point of this thing is that it’s not about you know getting an A on a paper it’s—the whole point of the early patient and having the humanities module is to get us to think so if they just did that I think it would be more effective” (15)</td>
</tr>
<tr>
<td><strong>Course Workload</strong></td>
<td></td>
<td>“do not have space for it (Psychology)” (6); “don’t attend a lot of lectures (9,10).</td>
</tr>
<tr>
<td><strong>Future Career Choice</strong></td>
<td></td>
<td>“Consultants in the hospital regard themselves as treat the patient, take the paracetamol, go home, where GPs like psychology…..are sort of all huggy wuggy” (17); “If you’re all about.. psychology and stuff you kind of seen—kind of like in medicine the GP is the lowest…it starts in medical school cos if you want to go into GP and you’re all about you know talking to patients about other problems than medicine then it’s like oh sure yeah that’s fine” (15).</td>
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