The value of psychology in health professional education: A health professional's perspective

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IN RESPONDING TO Upton's discourse arguing for reform of undergraduate health profession curricula to maximise the inclusion of health psychology, it is first important to concede the enormity of the task. Suggesting to psychologists that their subject may not be so crucial could be compared to selling Kyoto environmental agreement in Texas! After all, psychologists are inherently biased towards their subject (as indeed we all are), quite simply due to their immersion within it which convinces them of its scope, influence, and relevance to health professionals. Nevertheless, a response will be presented, arguing that health psychology need not be elevated in status within these programmes.

Upton constructed his argument around four key areas:

- What is curriculum content?
- Why is curriculum content important?
- What do studies of curriculum content tell us?
- How should curriculum content be chosen?

Each of these areas will be revisited within a discussion of *Curriculum content and its appropriateness*, which will examine the validity of the evidence upon which key conclusions are based: although a number of interesting issues are raised, the conclusions drawn may seem less definite with further exploration. Initially, however, a description of exactly what health psychology is will be presented. This is to establish respondent credibility, as an erroneous understanding would fundamentally undermine the response. A discussion of the major areas of concern will follow, and three short case scenarios will be used to illustrate some issues that may need to be considered to ensure that psychologists deliver appropriate material to health care professionals. General conclusions will then be drawn, focusing on the importance of interprofessional communication and collaboration to drive curriculum development forward to ensure that students, and ultimately patients, receive effective care.

Defining 'health psychology'

Unsurprisingly, looking back at my undergraduate health psychology text – Neil Niven's *Health Psychology – An introduction for Nurses and other health care professionals* (labelled 'required reading' incidentally) reflects my perception of the subject. Niven (1989) focused on three areas: *Process*, *Content* and *Models*. This largely mirrors my understanding of the subject: as a podiatrist I deal with patients: I need to communicate with these patients in order to gather the information that will help me establish an accurate diagnosis (a pivotal step in clinical practice, from which appropriate treatment should follow). However, communication can be difficult, requiring the use of different types of questions, attention to verbal and non-verbal cues and an appreciation of each patients individual needs and values. Therefore, communication and interpersonal skills are vital. This is why two major undergraduate podiatry textbooks – *Common Foot Disorders* (Lorimer et al., 2006) and *Assessment of the Lower Limb* (Merriman & Turner, 2002) provide chapters on these issues in their first sections. Communication also impacts on a majority of treatment regimens, with patients routinely asked to

participate in their treatment by following advice. Indeed, this concept is important, given the contemporary emphasis on patients becoming experts in their own care (DoH 2001; Donaldson, 2003). Therefore, understanding the factors influencing concordance are important as they can help maximise the likelihood that patients will follow guidelines or advice. Niven (1989) provided a focused insight to health psychology, demonstrating that the individual patient, and the patient-professional relationship, is important and complex, and that it is unrealistic to expect (or believe) that patients will respond to a single method of approach.

In contemporary terms the scope of the subject as described by Niven (1989) is somewhat limited, as the discipline has continued to evolve since its publication. Considering Ogden (2004) suggests that health psychology has developed significantly since Niven published his textbook in 1991. Presenting Matarazzo's (1980) definition of health psychology as *'...the aggregate of the specific educational, scientific and professional contribution of the discipline of psychology to the promotion and maintenance of health, the promotion and treatment of illness and related dysfunction'*, a broader role for psychology was described. This text emphasised the inadequacy of the traditional biomedical model on the basis that it fails to acknowledge a role for the individual, and social and environmental influences, on health and disease, and seeks to approach health and illness using a model encapsulating these factors. As a result, health psychology now encompasses various issues:

- What causes illness?
- Who is responsible for illness?
- How should illness be treated?
- Who is responsible for treatment?
- What is the relationship between mind and body?
- What is the role of psychology in health and illness?

These questions are undoubtedly valid, and it is clear that a complete understanding of health and disease requires answers to these questions. Presumably, a curriculum brimming with health psychology would focus on such information. However, we do not know if this information is a pre-requisite for, or in any way promotes, effective clinical practice. A useful analogy may be to consider the relationship between epidemiology and clinical medicine: Vetter and Matthews (1999) suggest that the difference between these two disciplines can be illustrated by imagining two doctors standing on a riverbank, witnessing a series of individuals floating down the river, drowning. Whilst the clinician would jump in and save as many people as possible, the epidemiologist would walk upriver to identify the source of the problem in an attempt to stop the individuals ending up in the river in the first place. Of course, the clinician can benefit from understanding the key concepts of epidemiology, and the epidemiologist gains from understanding clinical medicine. However, the key issue is that both roles are different, and the optimal level of knowledge overlap is unknown. The first point, therefore, is that it is by no means understood how much psychology a health professional needs, just as it is not known how much a psychologist needs to know about a health profession they are teaching to ensure optimal impact.

Curriculum content and its appropriateness

The conclusion that undergraduate health curricula are bereft of psychology seems to be based on three observations:

- There is a lack of detail, and inappropriate breadth, in the Standards of Proficiency as laid down by the HPC (HPC, Standards of Proficiency, 2003), and in the benchmark statements presented by the QAA (QAA, Subject Benchmarks 2001) which are a major factor determining curriculum content;
- Psychology is undermined, in terms of amount and positioning, within the curriculum;

- Other subjects (in particular the basic sciences), whose importance is questionable, are overemphasised within the curriculum.

These concerns will be discussed in turn, considering firstly if there is sufficient evidence of their legitimacy, and secondly, if they are unique to health psychology. This latter point relates to the fact that the concerns may in fact be symptomatic of more general curriculum difficulties, thereby weakening the contention that psychology is the Cinderella subject.

Standards of proficiency, subject benchmarks, and curriculum content

It is quite correctly identified that curriculum content is influenced by professional and regulatory bodies, who are seeking to ensure the standards of their members and registrants respectively. As such, representatives from these organisations are present at validation events to ensure that their requirements are satisfied (it is important to note that they attend for the purpose of evaluating both programme and institution). Whilst this has always been the case, the QAA in 2001 (with their *Subject Benchmark Statements*) and the HPC in 2003 (with their *Standards of Proficiency & Standards of Education and Training*) produced documentation intended to clarify their requirements. However, bemoaning the relative breadth and lack of specific material or detail suggests a misinterpretation of the role of these organisations and the standards set. The overarching purpose of the QAA is to ensure the quality of the programmes being delivered and/or the Institutions delivering them, and the HPC exists to protect the public and to ensure that all approved institutions and programmes fulfil the standards of education and training set out. It is not the intention of these documents to explicitly detail curriculum content. For example, in the foreword of the *Standards of Proficiency: Chiropodists and Podiatrists* (HPC, 2003) Norma Brook, president of the HPC, states that the document is intended to ensure that *'…registrants and potential registrants know what is required of them'* in terms of their professional practice. In any case, arguing for explicit definition of a curriculum at degree level and above could be viewed as epistemologically flawed. There is here a parallel with the challenge to professionalism associated with the outcomes movement which has provoked engaging discussions focusing on the complex, contextual, nature of professional practice (Black, 1998; Tanenbaum, 1999), and these discussions serve as a useful insight to the purpose of professional curricula. It seems reasonable to suggest that the HPC and QAA criteria are constructed as they are in recognition of the multiple ways in which a curriculum can be organised, described and taught, whilst still satisfying their requirements. For example, comparison of traditional and problem-based learning approaches to medical education suggested little differences between the two when knowledge based assessments were used (Wood, 2003). Although there may be advantages in terms of knowledge retention, this information suggests that similar outcomes can be achieved using different methodologies.

Even if the HPC and QAA standards were recognised as a valid mirror of curriculum content, the assumption that they overemphasise the basic sciences to the detriment of psychology can also be challenged. Whilst one standard is quoted with the implication that it represents the extent of psychology involvement, scrutiny of the *Standards of Proficiency* reveals that psychological skills are in fact integral to numerous statements. Table 1 illustrates this, by listing the standards that can be seen to involve health psychology.

A final issue regarding the role of the HPC and QAA relates to the concept of *threshold competency*. The concepts of lifelong learning and continuing professional development infer, appropriately, that the competencies attained during undergraduate programmes are those necessary to enter

Table 1. Standards of proficiency involving psychology, challenging the suggestion that psychology is reflected in few standards.

Standard No.	**Standard description** (full standards not consistently included due to length)
1a1	Understand the need to respect, and so far as possible uphold, the rights, dignity and autonomy of every patient including their role in the diagnostic and therapeutic process.
1a2	Be able to practise in a non-discriminatory manner.
1a3	Be able to maintain confidentiality and obtain informed consent.
1b2	Be able to work, where appropriate, with other professionals, support staff, patients, clients and users, and their relatives and carers: – understand the need to build and sustain professional relationship as both an independent practitioner and collaboratively as a member of a team; – understand the need to engage patients, clients, users and carers in planning and evaluating diagnostics, treatments and interventions to meet their needs and goals.
1b4	Be able to demonstrate effective and appropriate skills in communicating information, advice, instruction and professional opinion to colleagues, patients, clients, users, their relatives and carers.
1b5	Understand the need for effective communication throughout the care of the patient, client or use.
2b3	Be able to formulate specific and appropriate management plans including the setting of timescales: – understand the requirement to adapt practice to meet the needs of different client groups distinguished by, for example, physical psychological, environmental, cultural or socio-economic factors.
2c1	Be able to monitor and review the ongoing effectiveness of planned actitivity and modify it accordingly: – be able to gather information, including quantitative and qualitative data, that helps to evaluate the responses of patients, clients, and users to their care.
3a1	Know the key concepts of the biological, physical, psychological and clinical sciences which are relevant to their profession-specific practice.
3a2	Know how professional principles are expressed and translated into action through a number of different assessment, treatment and management approaches and how to select or modify approaches to meet the needs of an individual.

practice. The HPC requires all registrants to undertake a suitable programme of CPD *related to their practice* and it is notable, for example, that in the Continuing Education Programme for 2006–2007 organised by the School of Health Care Studies at Cardiff University, 'Psychosocial approaches to Podiatry' is scheduled for 5 March, 2007. The purpose of undergraduate health programmes is to produce threshold level clinicians, and a profession should not be judged solely in terms of that basic level, particularly when there is a regulated obligation to continual professional development.

The relative value placed on psychology within the curriculum

The conclusion that there is *'…unsurprisingly, a greater focus on other topics within the curriculum for health care professionals…'* seems to be derived from, firstly, a count of the number of modules with something like 'health psychology' in the title and, secondly, an evaluation of their place within the curriculum. It can be demonstrated that both approaches are simplistic, and underestimate the actual amount of psychology within the curriculum.

Using a 'module count' to determine the involvement of any subject carries inherent bias. Health curricula are generally taught using an integrated approach, where topics are introduced in a particular module but are then integrated into the clinical situation throughout the programme. Just as anatomy and physiology are taught in year one and then in subsequent years are applied and reinforced in clinic, so too can the same principle be applied to psychology. For example, whilst 'Behavioural Studies' appears in year two of the Podiatry programme on which I teach, it is important to appreciate that the clinical assessment form used in year one includes a section worth 25 per cent entitled *'Communication and interpersonal skills'*. This encompasses establishing a rapport with the patient and conversing with them to gather and synthesise information, to formulate an appropriate treatment plan, and to provide appropriate information and guidance. These skills are developed throughout all three years of the programme, with similar sections appearing on the forms used for both continual and end-of-year assessments in all years. Additionally, in the third year an assignment focuses on health promotion which requires the development of a patient education material, which is submitted with a detailed explanation of the underpinning rationale. Therefore, the notion that psychology appears once, receives minimal attention, and is subsequently marginalised is a misrepresentation which fails to appreciate the integrated nature of health programmes. There are some 6000 to 7000 treatments delivered each year in the clinic in which I work. The variety of patients encountered brings experience of a multitude of behavioural issues, personality types and attitudes which result in many discussions regarding how to cope in such situations. These range from patients who are depressed, demonstrate poor concordance, are facing life crises, or have learning difficulties or physical disability. Staff possess a wealth of experience, and have encountered many challenging situations such as, for example, Munchausen's syndrome (and Munchausen's by proxy), schizophrenia and neuroses which they are eager to share with students because the excellent, and important, teaching opportunity they provide is recognised. Viewing named modules in isolation as the only place where topics appear represents a simplification of health curricula.

Just as a 'module count' is biased, so too can emphasising its place in the curriculum. If a subject appears in first year, and, therefore, does not contribute to the degree classification, it is suggested that this undermines it. This suggestion is incongruous because the basic sciences, which are claimed to be overemphasised by health care professions to the detriment of psychology, *characteristically* appear in the first year. This is not because they are less important than

other subjects, but because they are foundation subjects. For example, how can the differential diagnosis of pain in a specific region be discussed without understanding in detail the anatomy of that region? Or how can the manifestations, signs and symptoms or treatment approaches to rheumatoid arthritis be understood if the nature of the disease is not appreciated? Contrary to Upton's implicit assertion, using the example of diabetes, that much of this knowledge is freely available and is expressed accurately and understandably, the level of detail required to practice effectively requires extensive study. For example, the differential diagnosis of rear foot pain encompasses a long list of both local and systematic disorders and navigating through these to arrive at a specific diagnosis requires a high level of knowledge. When considering this information it is also useful to consider that there are several 'red flag' diagnoses which it is dangerous to miss. A solid foundation in the medical sciences is vital for health professionals, especially for professions with clinical autonomy.

It is interesting to see Upton cite his own study comparing the opinion of level 1, 2, 3 and qualified dieticians which suggests that whilst students value knowledge of the basic sciences to the detriment of psychology the situation is reversed upon graduation. The study does suggest a trend, and provides interesting information on the appropriateness of the extant curriculum. However, the situation is unlikely to be this straightforward. For example, two potential sources of bias are the choice of basic science (biochemistry) and the discipline questioned. It may be that asking podiatrists the value of anatomy would yield a different result to asking them about biochemistry. Upton's finding could be reinforced by examining CPD uptake, where presumably there would be greater uptake for the psychology they were deprived of as students. It is not known if this is the case, but it does seem reasonable to suggest that the assertion could be confirmed if it were identified that psychology courses consistently recruit to target whilst courses involving basic sciences were struggling. To this end it is interesting that the 'Psychosocial approaches to Podiatry' course mentioned earlier had to re-advertise.

Reconciling the perspectives of psychologists and professionals

It seems reasonable to conclude that whilst health psychology cannot, and should not, be undervalued, the extent to which it should be involved requires debate. It is almost certain to vary between professions, but also between specialities within professions. These concepts can be illustrated by considering three clinical scenarios encountered by podiatrists. Similar situations exist in relation to other disciplines.

Scenario A: *Some clinical situations can be addressed perfectly well using the traditional biomedical model.*

A 25-year-old male presents with an onychocryptosis (ingrowing toenail). A piece of nail has physically penetrated the tissues at the side of the nail, providing a portal of entry for infection, and the GP has provided three courses of antibiotics over a six-month period. On the first appointment the podiatrist suggests that the best course of action is to remove the nail under local anaesthetic The procedure is performed and the problem resolves.

Scenario B: *Please don't underestimate the importance of the basic sciences.*

A 42-year-old man presents with a painful Achilles tendon, two months after receiving a steroid injection from his GP in the area. This was obligingly performed by his GP to help him participate in the upcoming London Marathon, three months away, and the patient admits that he had 'laid it on thick' about being desperate to take due to the obligation he felt to his chosen charity. Unfortunately, examination reveals a ruptured Achilles tendon. Knowledge of the biochemistry of Achilles tendinopathy is

available showing the problem to be one of degeneration and not inflammation, contra-indicating steroid injections due to the increased risk of rupture.

Scenario C: *To sell health psychology to me, show me how it can help me tackle the really important concordance issues in diseases such as diabetes.*
A 58-year-old female presents in clinic for her routine appointment. She was diagnosed with Type 2 diabetes eight months ago, and is showing signs of the development of peripheral neuropathy and peripheral vascular disease. She has developed an ulcer on her foot that is related to her poor choice of footwear, her love of cakes, and her failure to take the advice of numerous health care professionals. Concordance is a critically elusive issue in diabetes. No approach yields consistent results, and the problem of poor concordance continues with devastating results.

These three scenarios could be discussed at length by both health care professionals and psychologists, due to the complex issues they raise. However, they are included to draw attention to one concept: just as it could be argued that many practitioners get by with only basic knowledge of anatomy, physiology and biochemistry, so too can many practitioners get by with only basic knowledge of psychology: determining the optimal content of undergraduate curricula is a complex issue.

Conclusion

The nature of professional practice is complex, and determining the optimal curriculum for individual professions is not as simple as asserting that one subject is uniformly crucial to all and can solve a majority of its problems. The individual health professions have differing scopes of practice, and within each profession there is variety in terms of specialisation. It seems unlikely that it will be possible to define a core curriculum that is common to each without undermining, in some way, individual professions. Constructing this essay has been informative, and I am convinced that it is impossible to dismiss psychological issues. However, the answer may not be to bring more psychology in; perhaps in the first instance what is there should be re-emphasised to ensure that core principles are taught well, and examined appropriately. Of course, research identifying the effects of increasing content and/or emphasis would help to clarify just how curriculum design in this area should develop. A conclusion that seems inescapable is that health professionals must be receptive to the input of psychologists, and psychologists should think explicitly about the needs of the individual health professions. This will ensure that generic approaches are used only where appropriate, and tailored approaches are utilised effectively.

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