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University of BRISTOL

2014 Summer Education Day

Workshop Report

Topics

Welcome and update

Teaching Psychiatry and Mental Health in years 1-5

Psychiatry and Learning Difficulty

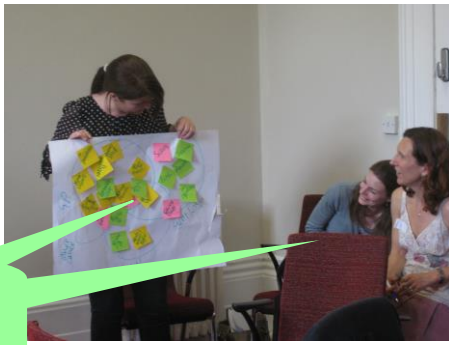
Prescribing for depression

Teaching Prizes

What do we know about student teaching in GP?

'Learning spaces' GP v hospital

Patients in teaching



Lovely, lively, enthusiastic consultant and registrar!

Really good day with inspirational speakers, Sophie Park very uplifting after lunch and got groups working and thinking well I thought - thanks for a great day

Speakers

Nicola Taylor	**Consultant Psychiatrist**
Jo Kingston	**ST5 in Psychiatry**
Veronica Cox	**Academic GP Trainee**
Sophie Park	**Senior Teaching Fellow, UCL**

Organiser

Barbara Laue

Dear GP teacher, July 14

Many thanks to those of you who attended this year's Summer Education Day. We hope that this workshop report will be useful to GP teachers of all years.

In the morning we focused on teaching Psychiatry. Nicola Taylor, a Consultant Psychiatrist from Bristol, outlined the changes to Psychiatry teaching. As many of you already know, from 2014-15 onwards Psychiatry will move to Year 4 and Pathology will move to Year 3. This move means that many students will not have any Psychiatry teaching until the end of Year 4. The Psychiatrists have therefore developed a plan how to introduce the topic of mental health in earlier years. In small groups we explored how GPs could contribute to mental health teaching in years 1-5.

Nicola and her colleague Jo Kingston, a specialty registrar, also covered therapeutics for Depression and diagnosing mental health problems in patients with Learning Difficulties.

For the afternoon session Sophie Park from UCL came to talk about her systematic review of all teaching in GP placements in the UK. She is a Senior Teaching Fellow at UCL and the Chair of the SAPC Education Research Group and a practicing GP in Hertfordshire. We compared the different 'teaching spaces' – hospital and GP, how students negotiate learning in the different settings and the role of patients in teaching. A summary of the information and discussions is contained in the following pages.

Please have a read and send us your comments.

We hope that you will all have a good summer and that you will continue teaching in the coming year.

Best wishes

From the Primary Care teaching team

Really good day with inspirational speakers, Sophie Park very uplifting after lunch and got groups working and thinking well I thought - thanks for a great day

Update of Primary Care Teaching

Year 1
- The students 8 GP sessions will be spread over 16 weeks from 2014-15

Year 2
- 4 clinical half weeks in GP and LITHE* in May /June will continue

*LITHE – Learning in the Hospital Environment

Year 3
- Psychiatry is moving to Year 4 and Pathology to Year 3
- Pathology will be paired with the MDEMO Unit
- There will be 2 GP sessions during Pathology
- Consultation skills sessions in year 3 will increase from one to two
- No OSCEs in year 3 anymore, long cases instead

Year 4
- All students will have their OSCEs at the end of Year 4

Year 5
- Consultation skills sessions will increase from one to two

outofourheads.net Good website for student artwork – inspiring stuff

Teaching psychiatry and mental health in Years 1-5

Nicola Taylor, Consultant Psychiatrist from Bristol

Very dynamic speaker - down to earth and authoritative

Bristol consultant Nicola Taylor provided us with an overview of the developments in teaching Psychiatry to undergraduates.

The main change is the move of Psychiatry teaching from year 3 to year 4. This will be balanced by a move of Pathology from year 4 to Year 3. In year 4 Psychiatry will be paired with Anaesthesia. Ethics will remain in Year 3 and be paired with Pathology.

Where psychiatry will be taught from 2015-16

Psychiatry will be paired with perioprative care and will be taught x4/year

PPC	Comp 1				Comp 2	RHCN						
Comp 1	PPC				RHCN	Comp 2						
RHCN	Comp 2				Comp 1	PPC						
Comp 2	RHCN	Christmas		OSCE	PPC	Comp 1	Easter		OSCE	Written Exam	Careers week	ssc

RHCN	Reproductive Health & Care of the Newborn.
PPC	Psychiatry and Peri-operative Care
Comp 1	Comp 1: Public Health Medicine/Epidemiology & Child Health.
Comp 2	Comp 2: Primary Care, Dermatology & Care of the Elderly.

Course length	4 x6 weeks blocks with a Gap of 3 weeks in between each.
Sites	5 AWP sites, 2gether and Som Par How can we use Weston (it's had great feedback) Swindon Academy will be opening
Supervision	Site tutor, Associate unit tutor at AWP sites Educational supervising in Pairs?
Teaching	To be determined
Formative assessments	To be determined
Summative Assessments	To be Determined.

Course content

Introduction: Asking and Assessing	Investigating and Formulating	Treating and Managing	Containing and Contextualising	Stigma, society and self care
History taking MSE Psychopathology Classification	Collateral history Imaging Bloods Polypharmacy Diagnosis	Psychopharmacology Psychological therapies Social Interventions	MHA Cultural psychiatry Epidemiology	Stigma The role of Psychiatry Self Care

Overview of planned Psychiatry/MH teaching in Years 1-5

Year	Psychiatry content
1	Behavioural Sciences and Whole Person Care
2	PiTHE
3	Central Teaching Liaison Psychiatry day Primary Care…Hopefully! ?MDEMO
4	6 Week Block CAMHS
5	Revision and DOSCE

Is the apprenticeship model or skills based model best for learning psychiatry - or a mixture?

How to help students to ask difficult questions? They often struggle with even social histories. Help them to pursue what to do with the answers e.g. to suicide questions, rather than just asking. Remember we may need to prime students to make the link between physical and psychological states.

Good for students to observe us, we are more powerful role models than we realize.

Students are more empathetic in Year 1 and seem to become more cynical and less patient centred as they progress through the course. Think about what happens to students somewhere between year 2 and 5 that "makes caring not cool" as something gets beaten out of them. Share own vulnerabilities - it's ok to say we don't know something - reduce perfectionism.

Think about self care - create the right environment and keep the balance between teaching the student and therapy on the right side - we are not their doctor but can encourage some housekeeping.

PITHE – Psychiatry in LITHE

(Learning in the hospital environment) a 4 week block at the end of Year 2
Pilot in South Bristol in May and June 2014 - 2 sessions of small group work to share ideas

- Be aware of sensitivities with mental health / bereavement issues? Baggage check for the students
- How does it feel talking to psych patients?
- How would it feel to be a psych patient?

Year 3

- In the GP placements and the MDEMO Unit we are planning to teach students about MH problems (depression, anxiety)
- One of the eight central study days in Year 3 will address MH problems
- Students will be offered Balint groups as part of their Junior Medicine and Surgery Uni

Psychiatry and Mental Health (MH) teaching in Years 1-5

General discussion points

- Outcome for all students should be how mental health impacts on **ALL** illness
- Need to be sensitive to the fact that students may have had mental health problems
- Should we talk about mental well being rather than illness?
- Standard history does not include question about mental health. Historically higher value placed on physical history. Symptomatic of our culture in which mental illness still has stigma attached to it to some degree.
- GP placements help to raise students' confidence
- GP is a good opportunity to learn how illness affects patients psychologically. GP's support this learning by teaching the link between mental and physical health
- GPs are well-placed to teach how we get across to patients the message that physical and mental health impact on each other
- Future curriculum change will mean that some students will not have had any psychiatry teaching by the time they come into GP - however, many in the group thought that this could be a positive thing, as the students will learn to take more of GP history and will not have as many preconceptions
- Watch students' body language, usually tells you when they don't know. Teach them that it is ok to say 'I don't know' and show them how you handle that

Top Tips relevant to all years

- Emphasise to students the benefit to them as F1/F2 of contacting Primary Care to get more background information about patients
- Patient selection for psychiatry is key, home visits can be a really rich source of learning
- Invite stable patients for short psychiatric histories
- Link physical and mental health in history taking
- Treatment plans – get students to commit to them
- "Tell me something I don't know about this patient" – exploring the background when working up their case presentations
- Be aware of the social/cultural context for each patient – there is usually more than one way of interpreting symptoms depending on patients' own experience and expectations
- Mental health problems are commonly part of multi-morbidity (and this might affect how able they are to cope with seeing medical students – similar problem in terminal care)
- "How do you feel about this patient?" – be aware of transference and how this can affect the consultation
- Teach about self care – their own mental health
    - caution with alcohol
    - try to have fun
    - read "Stress in Medical Practice"

Teaching Psychiatry and MH in the GP placements in Years 1-5 - Discussions

Year	Teaching
1	▪ Students have limited life experience ▪ Could it be overwhelming to include psychiatry for inexperienced students in years 1 and 2? ▪ To widen students perspective it might be a good idea to take them for a walk through more deprived areas or the inner city if you are located there or it would be convenient to go there ▪ As doctors we need to be aware that we lead a 'rarified' existence and that it is easy to be judgmental. Need to show students that we are human, share challenges, and tell them how we might feel about patients and situations ▪ Choose patients with mental health problems for visits ▪ Patient selection for psychiatry is key, home visits can be a really rich source of learning o Anxiety problems o Bereavement – could talk about then and now o Cancer patients ▪ Encourage holistic approach – listen to the 'story' rather than 'taking the history' ▪ Student struggle with the social history, spend time on teaching that ▪ It may be difficult for the students to make the link between the physical and mental. Encourage them to ask the patient how they feel about it ▪ Encourage debrief o In the debriefing encourage students to talk about how it makes them feel, share your own feelings. How does it make them feel? o Discussion of impact of chronic mental illness ▪ Get feedback from the patient. Speak to patient later how they felt about the interview and then feed that back to the students
2	▪ We identified that a well known mnemonic for a medical checklist (MJTHREADS)* was all physical and did not include any reference to mental health. This means that we are training our students to have a blind spot. ▪ Including a question about mental illness so it becomes part of the students' basic repertoire seems essential. ▪ Take them on a home visit ▪ Consider the whole patient ***MJTHREADS** This doesn't have a mental health question in it. Are we training students to develop a blind spot? **M**yocardial infarction **J**aundice **T**uberculosis **H**ypertension **R**heumatic fever/ **R**heumatoid arthritis **E**pilepsy **A**sthma **D**iabetes **S**trokes More medical mnemonics at http://www.medicalmnemonics.com/cgi-bin/return_browse.cfm?browse=1&discipline=Interviewing%20%2F%20Physical%20Exam

3	▪ Chronic illness ▪ Talk about mental health - how does it make them feel? ▪ How are they coping? ▪ Need to cover systems and core topics. Including the psychological could be quite challenging in the time available ▪ Opportunity to listen to stories - Emphasis on listening ▪ When we focus on examination and basic skills the mental health aspect 'goes out of the window' ▪ Ask about mental well being ▪ Need to create the right environment ▪ Role modeling talking about feelings engendered by a patient encounter. ▪ Share feelings about patients and how we manage them ▪ Need to watch our language and avoid derogatory terms such as 'nutter', 'bed blocker', 'crumble' ▪ Need to role model a non-judgmental attitude ▪ Building up a picture - Social history - Even that can be difficult for students
4	▪ Using surgery exposure/tutorials/case based discussions to help them to make diagnoses, consider treatments, and commit to decision-making regarding drugs vs. therapy (or both). ▪ We teach them how to assess someone in 10 min., with or without tools (PHQ-9 etc) ▪ Students often get opportunity to interview a patient alone whilst in GP, using a 45 min hospital type history, but also get exposed to the shorter typical 10 min GP consult ▪ Introduce idea of motivational interviewing ▪ Students overwhelmed and shocked at sheer numbers of psychiatric patients in GP, can also be shocked at how long it can take for patients to access therapies ▪ They gain exposure to acutely unwell psych patients ▪ We do not teach psychiatry formally, all is integrated into GP ▪ Ask student to consider the mind-body link in every consultation. ▪ Ask patients with mental illness who are currently "stable" to spend a longer time with students after surgery, to allow them to practice history taking/review complex pain issues/M.U.S, etc. ▪ Help students to understand community treatment and support structures (e.g. LIFT, Mental health matters, MIND, Samaritans, etc.), as well as thinking about the place for questionnaires such as PHQ-9 (many in group did not like these) ▪ We could invite a local Psychiatrist to come in and do a joint GP/Psychiatry surgery, with student observing and then having a 3-way reflection on mind-body interface. (Blue-sky thinking, but why not?!) 
5	▪ Ask the students to tell me something I don't know about this patient ▪ Patient selection for Psychiatry is key, home visits can be a really rich source of learning

Learning difficulty Jo Kingston, Specialty Trainee in Psychiatry

Classification

- Mild moderate severe profound LD
- Intellectual disability will replace the term LD

Verbal v non verbal makes all the difference in terms of how to communicate with these patients.
Assess whether it is possible to use a traditional history / mental state examination

- Anxiety is prevalent
- Distinguishing feelings and thoughts can be difficult
- Concept of time difficult
- Concept of death/suicide difficult
- People with LD have more loss
    - Children in special school more likely to move away
    - Carers likely to move away

How do you assess someone with mild LD?

<u>Avoid assumptions, easy to make them</u>

- Normal approach
- Simple sentences, one question at a time only!
    - What do you like doing?
    - Are you happy or sad?
    - What makes you happy / sad?
- Don't take problem as diagnosis
- Think broadly
- Biological symptoms – sleep, appetite, bowels
- Collateral history
- Observation
- Examination
- Don't forget
    - Eyes, ears, teeth, bowels, infection, pain
    - Eating, drinking and swallowing
    - Mobility
- Medications – could cause low sodium
- Ask yourself- Is the problem psychiatric or physical?

With medication - start low go slow
No two people with LD are the same.

How do you assess someone with moderate to severe LD?

- Use skills that we use to assess non verbal children
- Collateral history from parent/carer
- Use non verbal cues- behaviour
- Have they stopped doing things they previously enjoyed?
- Don't forget eyes, ears, teeth, constipation, uti, reflux in people with challenging behaviour
- Think side effects of medication? Low Na

Tips for prescribing in depression Nicola Taylor

- What we expect students to know
- No need to medicate mild to moderate depression
- Most anti depressants work within 1-2 weeks
- Takes 4 weeks to work out whether they work or not
- Can stop one SSRI and start another one the next day (except paroxetine)
- Can taper one while starting the other if on high doses
- Need more care with MAOIS and tricyclics. Stop tricyclics for 3 days before starting SSRIs
- If using SSRIs in adolescents use Fluoxetine, start with 10mg and increase to 20mg
    - Warn of suicidal thoughts and monitor weekly
- Citalopram and Paroxetine bad for discontinuation symptoms
- If wanting to stop Paroxetine, switch to Fluox as long acting
- Fluoxetine and Paroxetine block conversion of Tramadol from prodrug to active drug

Serotonin syndrome includes

- Restlessness
- Sweating
- Shivers
- Tremors
- Muscle twitching
- Jitteriness
- Confusion
- Convulsions
- Death

Special considerations

- Elderly - Watch for low Na on SSRI esp. female underweight patients with COPD, consider Lofepramine instead
- Bleeding with SSRIs, especially if on anti coagulants
- Adolescents - Can give low dose SSRI while waiting for CAMHS
- Bipolar - Quetiapine is now first line for depression in bipolar
- Pregnancy - Fluoxetine is ok
- Breast feeding - Sertraline is ok
- Tramadol - Big trigger for serotonin syndrome if given with Fluoxetine
- Ok to stay on anti depressants long term if risks outweigh the benefits
- Pregabalin
    - Doesn't interact much with other things so can be useful short term intermittently for anxiety
    - Can be addictive and create tolerance, so not for use long term in the younger patient. Too similar to benzos ...
    - Pregabalin 75mg half to one prn for up to 2 weeks normally

How much teaching in GP in the UK? Veronica Cox **Academic Clin. Fellow**

Bristol offers around 7 weeks GP placements over 5 years in total
The range in UK medical schools is 4-20, so room for improvement

Current Gaps in Bristol Curriculum

- Rationing and commissioning / Urgent care / LD / Genetics / Etc
- Commonalities and tensions between GP and hospital based teaching

Teaching Prizes

Congratulations

To the winners of this year's Teaching Prizes

Year 1 Trish McQuoney	Air Balloon Surgery, St George, Bristol
Year 2 Susan Green	Shirehampton Group Practice, Bristol
Year 3 Shanta Nair	Bartongate Surgery, Gloucester
Year 4 Jane Edge	Horfield HC, Bristol
Year 5 Ronita Porter	College Way Surgery, Taunton

Runners up were

Year 1
Hugh Davies, Claire Rowell, Emma Mason, Sarah Wigmore, Mike Armstrong, Peter Young, Daniel Hirsch, Raiyan Talha, Hannah Condry, Mark O'Connor, Rachael Kenyon,

Year2
Geoff Hogg, Simon Tucker, Lanil de Silva, Jane Edge, Kate McMaster, Karen Prees, Geoff Hodge

Year3
Elise Godfrey, Thomas Agombar, Bernard Newmarch, Darragh O'Driscoll, Nick Alexander, Fiona Peach, Martin Wicks. Jenny Parvin

Year 4
Guy Worsdall, Joe Hogg, Sam Davies, Christopher Chubb, Pro Sarker, Sarah Jahfar, Julianne Matthies, Rebecca Hennessy

Year 5
Ian Cameron

All nominees will be informed and will receive their student comments.

What do we know about student teaching in General Practice? Evidence from research

Sophie Park Senior Teaching Fellow, UCL, Chair Education Research Committee, SAPC, practicing GP

Is GP teaching as effective as hospital based teaching? Exploring commonalities and tensions between GP and other learning settings.

What are the opportunities and challenges of hosp v GP teaching?

We started with small group discussions and drew Venn diagrams to show what students were learning in which setting. This showed a considerable overlap.

Learning opportunities in GP

- 1:1
- Small environment
- Maslow – food and drink
- GPs know their patients
  - Continuity of care
  - Family dynamics
- Longitudinal learning
- Home visits
- Diversity of presentations
  - Breadth of problems
  - Can plan and pick and choose patients
  - Early presentations
  - Range of severity
  - Patients are less unwell, more relaxed

Learning opportunities in hospital

- Patient and student have more time
- More predictable
- Team working/MDTs
- Acute emergencies
- Technical procedures and interactions
- Easier access to investigations, physio etc
- Availability of experts in their field

Learning challenges in hospital

- Patients often very sick
- Students kept away from acute severe cases
- Less variety
- Visiting time
- Students anonymous
- Too many students for patients
- Lack of belonging to a team, students lost in mêlée

How can we help our students to negotiate the different learning spaces?

- Help them integrate their learning
  - Do 'linking work' with students
  - Signposting
  - Get students to articulate what would happen in hospital
  - LNA (learning needs analysis)
  - Clear learning objectives
- Be aware of our prejudices and what we role model, need to be professional and not 'emotional', avoid judgmental comments about hospital colleagues
- Mentorship
- Emphasise commonalities
- Understand the interface ourselves

The student roles

- Active participant
  - Makes the student feel legitimate in their learning endeavours
  - Performance rehearsal
- Passive observer
- Active observer

<u>Blurring between student and patient roles – both can be recipients of knowledge</u>

Patients in teaching

- Can feel objectified when 'talked about' but not included
- Important to actively include patients in the teaching and discussions. This makes them feel included and less objectified
- <u>Therefore we should aim to actively involve the patient in the teaching process</u>
- A patient is somebody with a story to tell or evidence of illness to show
- Pretend patients or somebody who has been a patient in the past
- Patients as expert teachers
- Patients can be invited, accidental, virtual (scenarios), simulated (role play, dummies)

Hot patients

- Not worked up 'We think…'
- Student more involved

Cold patients

- Already worked up
- 'What is the answer?'

Consent

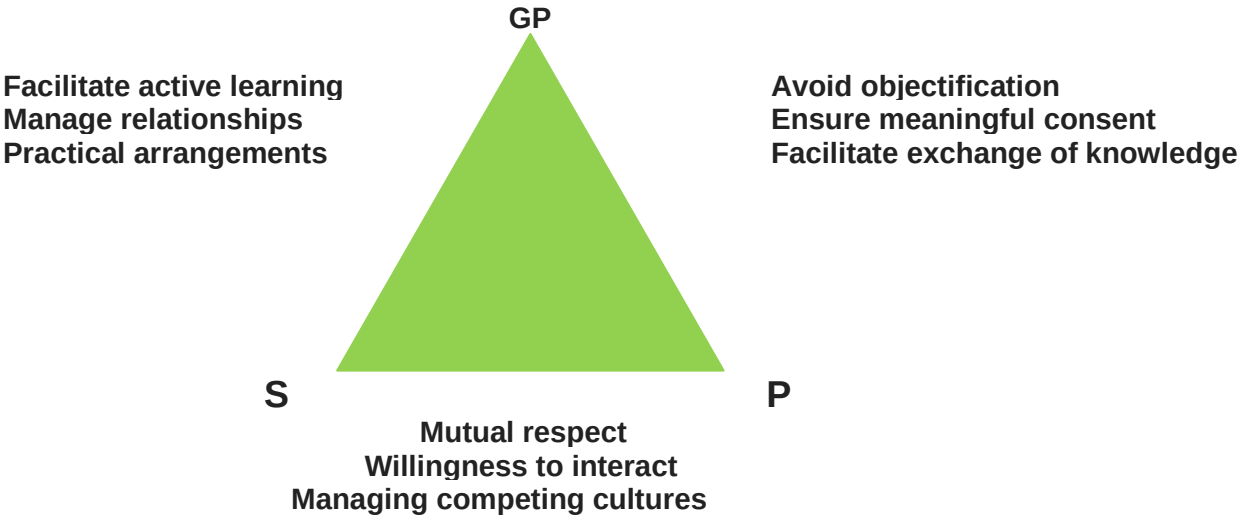
- More implied in hospital

- Think when and where to inform the patient that a student will be present
    - At booking
    - On arrival
    - In the waiting room
    - When calling patient through

Information

- Inform patient about the stage the student is at
- Introduce the student
- Summarising and checking back that the student's history is a fair representation
- Primacy of the patient problem

The GP has a powerful role as broker in the learning triangle



Increasing patient participation in teaching

- Please give this student one tip for the future?
- Please tell this student what they did well and how they can further improve.

What did the research show?

Students go between spaces. Interactions are triadic: GP – student - patient

- When patients felt included in treatment they felt much better
- GPs have a powerful role as broker of interactions
- Students need support to manage competing cultures between GP and hospital
- What can we do to help include both students and patients?
    - Ask the patient - is there one tip for this student to become a better doctor
    - Encourage the concept of whole person care
    - Be professional ourselves
    - Ask students to sign a card to send to patients after a teaching session - include some feedback from the students about how useful it was
    - Signpost in a consultation when the consultation moves towards teaching "I'm just going to put X on the spot a bit here and ask …"
    - Think about teaching opportunities, are they planned or unplanned, what is the patient expecting?
    - Objectify patients less!
- NB some reduced empathy noted when student is present especially when patient felt objectified

Workshop evaluation

Many thanks for completing the online survey. Your comments are very helpful for future workshop planning. Any suggestions for our workshop programme are very welcome.

1. Which Academy is your practice attached to?			
Bath:		15.8%	3
Gloucester:		10.5%	2
North Bristol:		21.1%	4
South Bristol:		15.8%	3
North Somerset:		5.3%	1
Somerset:		21.1%	4
Swindon:		10.5%	2

Good to have a refresher of whats happening across the 5 years to see where our teaching fits in

2. Welcome and update of Primary Care Teaching			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		0.0%	0
Good:		68.4%	13
Excellent:		31.6%	6
Did not attend:		0.0%	0

3. Teaching Psychiatry and mental health in years 1-5 - changes and developments			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		5.3%	1
Good:		42.1%	8
Excellent:		52.6%	10
Did not attend:		0.0%	0

Very dynamic speaker - down to earth and authoritative

4. Teaching Psychiatry and mental health - small groups			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		10.5%	2
Good:		63.2%	12
Excellent:		26.3%	5
Did not attend:		0.0%	0

Made us concentrate on how to keep psychiatry in focus

Filled in lots of my gaps as well as understanding how much the students should know

5. Treating depression			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		5.3%	1
Good:		31.6%	6
Excellent:		63.2%	12
Did not attend:		0.0%	0

Made me reflect on own practice

6. Psychiatry and learning difficulty			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		10.5%	2
Good:		47.4%	9
Excellent:		42.1%	8
Did not attend:		0.0%	0

7. Prize giving			
Poor:		0.0%	0
Below average:		5.3%	1
Satisfactory:		21.1%	4
Good:		36.8%	7
Excellent:		15.8%	3
Did not attend:		21.1%	4

8. How much teaching in General Practice in the UK - intro talk			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		31.6%	6
Good:		31.6%	6
Excellent:		15.8%	3
Did not attend:		21.1%	4

9. Is GP teaching as effective as hospital based teaching?			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		26.3%	5
Good:		31.6%	6
Excellent:		21.1%	4
Did not attend:		21.1%	4

10. Patient participation in General Practice medical education			
Poor:		0.0%	0
Below average:		0.0%	0
Satisfactory:		26.3%	5
Good:		31.6%	6
Excellent:		15.8%	3
Did not attend:		26.3%	5

Useful to think about getting patients more involved

11. Please rate the workshop overall			
In truth, not really very useful:		0.0%	0
Picked up one or two useful things:		21.1%	4
Plenty of relevant stuff for me as a GP teacher:		52.6%	10
I came away feeling highly informed and inspired:		26.3%	5

First one of these days I have attended - enjoyable and informative

Thanks Really worthwhile

Reflective Template

Year 2&3 GP Teacher Workshop	
Date/Venue/Hours	24th June 2014, Engineers' Hse, Clifton, Bristol **6 hours**
Description	**Summer Education Day**
Reflection and Feedback	
What did I enjoy? What have I learned for my teaching and for my GP work	
Forward Planning	
How can I use the ideas from this workshop in my teaching? How could I share the ideas from today with my colleagues?	
Key points to remember	
Name, date, signature	