University of BRISTOL

# Report

## GP Teachers' Workshop
## For 2nd and 3rd Year Courses

**Engineers' House, Clifton, Bristol**
**Tuesday 12th April 2011**

**Review of Year 2&3 and student feedback**

**Psychiatry teaching in Year 3**

**Teaching therapeutics – SSRIs**

**Top teaching tips for Year 2&3**

**Teaching clinical skills using the OMP method**

**Guest lecturers**
John Potokar
Kate Seddon
Julia Vasant
David Little

**Workshop contributors**
Sarah Jahfar
Melanie Blackman
Nita Maha
Chreyl Atter

Dear GP Teachers, 31.5.11

Thank you to all of you who came to this workshop and apologies to those who couldn't make it due to school holidays.

In the morning Kate Seddon, Teaching Fellow in Psychiatry, gave us an overview of the curriculum for Psychiatry and how this is being taught in the academies. This helped to gain a better understanding how teaching Psychiatry in the GP placements fits into the jigsaw. We all realised that the delivery and quality assurance of Psychiatry teaching is a complex affair. In small groups we explored which psychiatric conditions we could best teach in Primary Care and whether and when we should teach about somatoform disorders.

John Potokar, Consultant Psychiatrist, led a workshop on SSRI prescribing. This served a double purpose. It reminding us what to consider and how to prescribe SSRIs safely and also showcased a teaching method – short presentation followed by discussions in pairs and whole group discussion. Working through an evolving patient scenario highlighted the pitfalls of prescribing SSRIs. Delegates expressed a desire to use the same scenarios with their practice colleagues and John has kindly made his scenarios available.

The Teaching Fellows from the Bath Academy, Julia Vasant and David Little, gave a demonstration of the 'One minute preceptor' model (OMP) for teaching clinical skills to 2nd and 3rd year students. We are grateful to the 5th year Bath students who spared some time to slip back into the roles of younger students.
And, as always, there was time for delegates to raise issues and share teaching tips.

This year we trialled a new system for our workshop evaluation. We asked you to log on to an online survey the day after the workshop. Most of you did, thank you very much. We are pleased to say that mostly you were happy with the day, please see feedback at the end of this report.

We are always interested to hear what you think about our workshops and keen to hear your ideas. If you have any teaching tips or information you would like to pass on to other GP Teachers, we would be pleased to publish them in our newsletter.

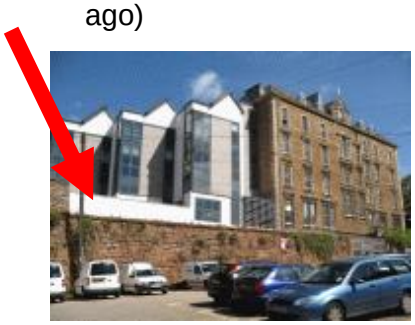
Kind regards

Barbara Laue

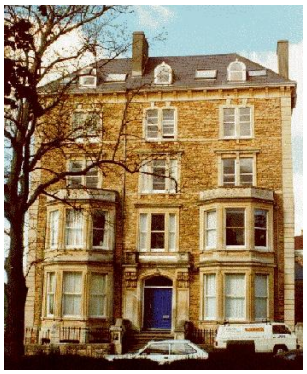
Poems, images and reflections in this report from student work at
http://www.outofourheads.net/oooh/handler.php?page=homepage
A site created by Trevor Thompson

## Changes at the University

- Bristol Medical School has been reorganised from 5 'departments' to 3 'schools'
- Primary Care is part of the 'School of Social and Community Medicine'
- Prof. Jenny Donovan is head of this school
- Primary Care Teaching Office has moved to Canynge Hall (where it was 10 years ago)



**Canynge Hall - new extension**



**Canynge Hall – the front door some of you may remember**

## Year 4 Gp placements

Most students now have a 4 week placements in one practice rather than 2x2weeks in different practices. The feedback shows that most GPs and students prefer this. Two week rural attachments are still possible.

## Year 5 GP placements

This academic year is the first time that students have been able to learn in General Practice. They go to practices in pairs for a 2 week attachment.

## Teaching in the Academies and GP Academy leads

### GP TEACHING IN THE ACADEMIES AND GP LEADS

| | N. Bristol | S. Bristol | N. Somerset | Bath | Glouc./ Chelten. | Somerset | Swindon |
|---|---|---|---|---|---|---|---|
| Year | Barbara Laue | Sarah Jahfar | TBA | Melanie | Anne Hampton | Andrew Tresidder Charles Macadam | Richard Carter |
| 1 | | | | | | | |
| 2 | | | | | | | |
| 3 | | | | | | | |
| 4 | | | | | | | |
| 5 | | | | | | | |

## Year 2

### Year 2 final assessment and attendance form

- 238 returned forms
- 43 students missed 1 session
- 1 student missed 2 sessions (serious illness)

Reasons for missing sessions
- 37 Illness
- 3 Volcanic ash
- 3 DNA/blank

- 'I really enjoyed these sessions as Dr X was really helpful and made us feel comfortable, so you felt you could ask about anything you didn't understand'
- 'The GP setting is always the place I feel I grasp the examination'

- 'Fantastic. With interesting patients and an interactive doctor it is the best form of teaching I have had'
- 'The best teaching and clinical skills definitely occurs in the GP setting'

In Year 2 we collect **student feedback** only once at the end of the course. We are still waiting for some Year 2 forms from this year to be sent in. The figures in the following slide and the student comments above are from last year.

### Student Feedback Year 2 (2009-10)

Based on **114 returned forms** (175 in 2008-09)

| | | |
|---|---|---|
| Our GP teacher made us feel welcome | 114 | |
| Our GP was an enthusiastic teacher | 114 | |
| Our sessions were well organised (started on time, well planned, well structured) | 114 | |
| We saw 2 or more patients in each session | 102 | |
| The GP teacher observed me taking a history and examining a patient | 114 | |
| The GP teacher commented on our skills during the sessions | 114 | |
| The GP teacher gave me individual feedback at the end of the last session | 107 | **94%** |
| I found the feedback from my GP teacher helpful | 107 | |

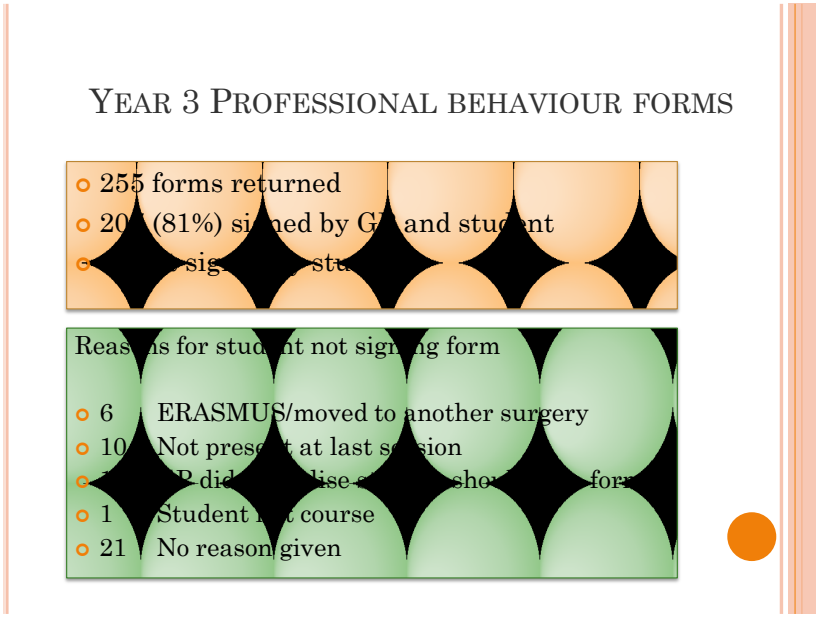
This is very good

Well done!

Thank you

## Year 3

In Year 3 we ask for professional behaviour assessment forms and student feedback forms twice a year. The following relates to Units 1&2 for 2010-11




- 'More confidence in interviewing patients and not sticking to a rigid regime when taking a history.'
- 'Allowed me to gauge what kinds of questions are important and how to ask the more difficult ones.'
- 'Feel more confident identifying signs on examination as opposed to simply going through the motions.'

- 'Very interactive, variety of patients, remind of the fact that within each specialty, each patient still has other problems – holistic model.'

- 'Very helpful to be in a small group and hear how everyone takes a psychiatric history – the different ways of doing things and what works. Very useful to go on home visit.'

## STUDENT FEEDBACK YEAR 3 UNIT 1&2
## COMPARISON OF 2009-10 AND 2010-11

BASED ON 179 AND 223 RETURNED FORMS

| | 2009-10 | 2010-11 |
|---|---|---|
| | Yes | Yes |
| Our GP teacher made us feel welcome | 179 | 223 |
| Our GP was an enthusiastic teacher | 178 | 222 |
| Our sessions were well organised (started on time, well planned, well structured) | 178 | 221 |
| We saw 2 or more patients in each session | 164 | 198 |
| The GP teacher observed me taking a history and examining a patient | 177 | 223 |
| The GP teacher commented on our skills during the sessions | 178 | 223 |
| The GP teacher gave me individual feedback at the end of the last session | 170<br>**95%** | 217<br>**97%** |
| I found the feedback from my GP teacher helpful | 175 | 218 |

**Psychiatry - Small group reports – 1. Which patients and conditions to choose**

Small group teaching in Psychiatry is an opportunity to put the focus firmly on the patients and their stories. Try and create an informal atmosphere to help the 'stories' to flow

<u>The patient in the Psychiatry teaching session</u>

- Focus on 'stories' rather than 'histories'
- Create an informal atmosphere to 'help stories to flow'
- Allow conversation
- Patient can tell their story
- Patient experience
- Some patients can talk about decades spent as a service user
- How diagnoses develop and treatments and management change
- Patients' physical illness – explore the interchange between physical and psychological
- Patients with insight – students can learn from the patients view
- Patients gaining confidence
- Valuing and respect for patient's role

<u>The student in the Psychiatry session</u>

- Same age patients – new experience for students, increased awareness of life stories
- Pre-session counselling and debrief. Need to be aware what is going on in students' own life. Student issues, for example depression, mental illness in their family

<u>The GP in the Psychiatry session</u>

- GPs learning new things about their patients

<u>Organising the session</u>

- Asking students what they want to see, setting learning objectives
- How to bring in a patient
- Task setting
    - 'While listening look out for…'

Patients to choose - conditions

- Choose 'GP patients', not secondary care patients
- OCD
- Bipolar
- Depression
- Anxiety
- Alcohol dependence
- Drug addiction
- Postnatal depression
- Stress
- Patients who recovering/recovered
- Somatisation
- Personality disorder/spectrum of personalities
- CFS
- Fibromyalgia
- TATT
- Health anxiety

Patients to choose – other opportunities

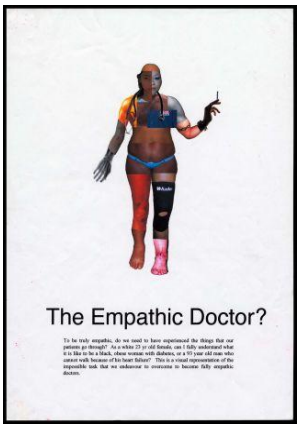
- 'Expert patients'
- Home visits
- Carer's perspective
- Widow of patient with dementia

Learning objectives

- Recognising mild symptoms/pre-disease
- Prescriptions and alternatives
- When to prescribe
- Why to prescribe
- Other resources and support
- How to cope with psychiatry in general Practice
- Self care
- Coping strategies

Wider topics for consideration

- GPs role?
- The consultation as therapeutic intervention
- Psychiatric conditions impinging on medical conditions and vice versa
- Students as therapy
- Patients' view of services
- 10 minute consultations
- First assessment
- Use of time
- Constructing the story
- How mx of psychiatric conditions has changed
- Compliance/adherence
- Benefits of mental illness (association between creativity and mental health)




**Reflection**

To be truly empathetic, do we need to have experienced the things that our patients go through? As a white 23 year-old female, can I fully understand what it is like to be a black, obese woman with diabetes, or a 93 year-old who cannot walk because of heart failure? This is a visual representation of the impossible task that we endeavour to overcome to become fully empathetic doctors.

Anon

At

http://www.outofourheads.net/oooh/handler.php?page=homepage

Specifics/skills

- Assess suicide risk
- MSE
- Psychosis assessment
- Screening for alcohol abuse
- Using drugs in Psychiatry
- Sleep hygiene
- PHQ9 – QOF questionnaire
- Asking about criminal activity

Barbara, May 2011

## Psychiatry - Small group reports – 2. Somatising Disorders with John Potokar

The group was made up of Dr Potokar and 9 GP's from a wide geographical area, representing a mixture of inner city, culturally diverse and rural practices.

The GPs said that they ask a variety of patients to come in for the 3rd years during psychiatry- substance/alcohol misuse, anxiety/depression, Bipolar, dementia (practice MMSE) and one said she chose a cancer phobic patient.

The point was made that our job in GP is to teach students about psychiatric conditions that they are unlikely to see in Secondary Care. We have heard stories of F1/F2 doctors being unprepared for the mental health issues that present across specialties, as they have not be exposed to the level of psychiatric illness generally seen in GP.

Dr Potokar asked us for our opinion on how (and even whether) **somatising disorders** and the mind/body interface should be taught at UG level.

We all agreed that it should but that 3rd year was too early to broach in any depth. The students do not have sufficient knowledge to start trying to determine what it somatising and what is pathological at this stage. We thought that COMP 2 in Year 4 or PPP in Year 5 would be the best times.

Dr Potokar asked us whether we would feel competent/confident to teach on the subject of somatisation. We all agreed that we would need a framework from which to teach such a complex subject. We made a few points:

1. The difficulty, but great importance, of recognising it early, to avoid over-investigation and spiralling anxiety.
2. Students need to be aware of SD, but cannot be expected to understand in depth. They have no continuity of patient care and will be lucky to see the same patient twice in most of their attachments.
3. We all need to be aware of the role of culture, gender, race, age in illness presentation.
4. It is very hard to combat SD in the light of reinforcement by specialists who do too much investigating and students need to understand this.
5. We would need to know what the best evidence based treatments are (counselling therapies, says Dr Potokar) and whether these are available to our patients. The group reported variable availability of therapies in their areas. Mindfulness, IAP programme, books on prescription can be beneficial. Medication, such as citalopram or paroxetine can be helpful at times.
6. We thought that we need to inform the students about the culture of health costs in the NHS and the strong reality of resource limitations. Also how private medicine can complicate care in people with SD.
7. How would we assess a module on SD? An MCQ would appear to be a rather crude tool. The group favoured the idea of an OSCE with an actor and a very thick set of notes by the bedside!

Sarah Jahfar May 2011

## Psychiatry - Small group reports – 2. Somatoform disorders with Kate Sutton

Initial discussion focussed on the 3rd year psychiatric teaching block .It rapidly became clear that all GPs present thought that this topic would be best addressed in the GP attachments in Years 4&5. It is a problem which is found much more commonly in General Practice than Secondary Care Psychiatry.

- This is a very complex subject which is best taught after some general clinical experience.
- Students need experience in routine patient problems before thay can begin to recognise some of the patterns which might indicate a somatoform disorder.
- Students,especially at the beginning of the 3rd year will not have enough of this background.
- The limited time spent addressing Psychiatry in general practice in the third year does not allow enough time for this subject.
- The third year teaching format with invited patients makes an encounter with these type of patients more difficult.
- In the final 2 years students attend lots of routine GP consultations. Since these patients are frequent attenders they will present and provide an opportunity for teaching and discussion.

Themes/issues associated with somatoform disorders

- Cultural and language differences
- Interpersonal abuse
- Stigma and shame

Secondary care superspecialisation can lead to multiple referrals and investigations with no central coordination to recognise the link of a somatoform disorder.payment structures in healthcare can give physicians reasons to collude with these patients.
Continuity of care: A physician who knows the patient well is less likely to refer or investigate inappropriately

Aims and objectives

Recognition

- Students need to recognise the characteristics of these patients- anxiety,unexplained symptoms,other conditoions eg Irritable Bowel Syndrome ,frequent attendances ,many previous normal investigations etc.

Getting the problem into the open

- It is quicker for a GP to give a quick reassurance or order an investigation than to discuss openly the possibility of a somatoform disorder. The group felt that this level of discussion is only likely to happen when a physician knew the patient well and was perhaps beyond the scope of undergraduate work.

Treatment

- Specific psychotherapy and group workshops .The place or otherwise of drugs. Periodic reinforcement of psychological stategies is often required

Teaching students about somatoform disorders

- Teachers felt a lack of confidence in teaching in this complex area and felt that clear guidelines or a teaching framework would be required.
- The group felt that a lecture on this would be appropriate.
- A 5thyear themed surgery and/or tutorial in GP attachment.

Student assessment

- Carefully structured multiple choice questions would be appropriate.
- An OSCE station with an actor and an examiner .This would require very careful coaching of the actor to ensure a robust marking scheme

Cheryl Atter, May 2011

**Alive**

As the sun rises in the east and
sets in the west,
life's transient moments
pass me by, sailing swiftly on
soothing winds that never say 'goodbye'.

With one blink I am forever blind.
Never sensing one's look, never
feeling one's smile.
Being a bird with golden wings
who is grounded all a while.

All around me people stop and stare,
their dawning realisation of what
is really there. A world of sumptuous sensuality
just waiting for us to taste,
like a bird finding its wings and flying away in haste.

The miracle of life is not to live
but to be alive. To grasp our happiness
and allow us to thrive.
I know now I must stop and stare
and realise what is really there.

**Hayley Penhale**

**Reflection**
I wrote this poem to explain what it really means to be alive. Life is full of transient, intangible moments, many of which pass us by. I feel as a doctor we really need to understand what it is to really be alive as it isn't just somebody's physical health that keeps them well. This poem attempts to explore the isolation life can bring when searching for a sense of fulfillment. As a doctor we should aim to relieve this isolation.

**SSRIs – potential prescribing pitfalls – workshop with John Potokar**

Working through these scenarios with John Potokar highlighted and reminded us to carefully consider side effects and interactions when prescribing SSRIs, in particular GI bleeding and interaction with common painkillers like Tramadol via the cytochrome system.

You may like to share these scenarios with colleagues in your surgery

A 42 year old married self employed taxi driver who has recently joined your practice phones to say he is experiencing severe abdominal pain. You see from his notes that he has been taking paroxetine 30mg daily for social anxiety disorder and that your colleague started him on indomethacin for OA 3/52 previously. You see from his notes that he is an ex IVDU, claiming to have injected heroin on a couple of occasions 20 yrs ago. He denies using illicit drugs since that time. You arrange to review him shortly, but events take over and he is admitted to hospital with a haematemesis.

**Could his bleeding be related to his psychotropic medication?**

He is quickly discharged and 2 days following this he attends your surgery, complaining of severe anxiety symptoms. The paroxetine and indomethacin were stopped in hospital.

**Could his anxiety symptoms be related to stopping paroxetine?**
**If so what other features would you look for?**

You decide to restart an SSRI but blood tests done in hospital demonstrate elevated LFTs (subsequently found to have hepatitis C). What and how would you prescribe?

A colleague chooses fluoxetine, as feels it will cause fewer problems if he misses doses or stops taking. 3 days later he re-attends complaining of increased anxiety, panic attacks and insomnia.

**What is psychopharmacological explanation?**
**What other features may occur and what would you advise?**

He does well but 6/12 later his OA pain has become severe despite appropriate strategies. You start him on tramadol 100mg TDS. He is still taking fluoxetine 40mg. Three days later his concerned wife phones to say that he appears very unwell. You attend and find him confused, anxious and sweating profusely. The OA pain remains severe.

**What is psychopharmacological explanation for his continuing pain?**
**What are his symptoms due to and what other features would you look for?**

His fluoxetine is gradually titrated down and stopped without problem. F/up tests for his raised LFTs reveal that he has Hep C and he is referred and subsequently starts on combination interferon and ribavirin. Two months later he becomes irritable, **ANXIOUS** and low and is referred back to you for assessment.

**What is psychopharmacological explanation for these symptoms?**
**What do you do from psychopharmacological perspective?**

## Top TeachingTips for Year 2&3 - small group session

Highlights

- Students enthusiastic, can ask more questions
- Variety, breaking up surgery
- Taking you back to your 'love of medicine'
- Students challenging you
- More learning and increased confidence
- More time with patients and gain more in depth knowledge of patients' lives
- Practical skills
- Encourage confidence in students
- Get to know students, learn from each other
- Feedback skills

| **Challenges** | **Solutions** |
|---|---|
| ▪ Finding patients | ▪ Have a 'patient bank'<br>▪ Nurse and specialist nurse list<br>▪ Home visits, eg COPD |
| ▪ Relying on patients turning up | ▪ Take patients off 'urgent list'<br>▪ Having 'standby patient you can call at the last minute<br>▪ Role play the patient yourself |
| ▪ Time – long session | ▪ Plan the session/create focus for the session<br>▪ Stick to timetable/Learning objectives<br>▪ Have a break in the middle |

Compariosn of Year 2 and 3

| | **2nd Year** | **3rd Year** |
|---|---|---|
| **Knowledge** | Little knowledge<br>Focussed on a system | More knowledge (some forgotten)<br>Trying to integrate knowledge |
| **Skills** | Basic clinical skills<br>Enthusiastic | More developed |
| **Attitudes** | More student like | More professional |
| | **Adjust teacher expectations** | |
| **Objectives** | Introductory<br>'Taskey' | Focus on assessment/tasks<br>Autonomy/learning skills |

Varying student ability

| **Good student** | **Not so good student** |
|---|---|
| Focus on reasoning | Can involve students going too far down the wrong track |
| Realise for themselves with facilitation | Lacks self reflection |
| Facilitate decision making | Needs more guidance |
| Flexible | Looking for more rigid framework |

Clerking portfolio in Junior medicine and Surgery in Year 3

- Dominating teaching session, interrupts group learning
- Lots of patients in hospital
- Students nervous, won't get them done
- Can have group patient?
- Presenting patient back

Managing the group (Year 2and 3)

- Trying to encourage participation/facilitation
- Different roles among students
- Ask students questions
- Keep a note of who has done what

Teaching topics/issues

- Hospital v GP history taking
- Progression through the year
- Useful questions/focussed history
- Thyroid, breast, vascular forgotten

Mixed groups in Year 3 (students part of different Units)

We try very hard not to put students from different Units into the same group. Very occasionally this is the only solutions due to student numbers and other administrative issues. Students may possibly experience this as disjointed learning and worry. They may not be at a stage or lack the maturity where they can view every patient as a learning opportunity.

The group came up with some suggestions

- Focus on general learning needs
- Could have one patient for each of the different Units
- Could ask students to teach each other
- Chronic disease patients with co-morbidities
- Teach simple things first

Barbara Laue, May 2011

**Top Teaching Tips - small group**

The group discussed various aspects of teaching that applied to both 2nd and 3rd years. The majority of the group taught 3rd years (2 only teaching 2nd years) and there was 1 new teacher.
I have covered most of the topics we discussed with a variety of ideas from all participants.

**Preparation**
All agreed this was a difficult job – finding patients can be very stressful. Varying opinions as to whether this is best done well in advance or short notice – depends on organisation of the patients. Some send letters to confirm, others telephone.
Idea of having willing patients on practice intranet or a personal 'secret' list!
Nursing home or housebound patients as home visit can be useful. Most arranged for 2 patients over the session.

**Best type of patient**
- Agreed that the best patients were those with a story and probably this is more important than signs. With 2nd years signs less important.
- Retired patients good. Expert patients can be good.
- Could have a quick patient with signs with more complex patients for history taking.
- Helps to brief patient about where to start with history.
- Could do a joint injection with students present, ECG before session and review, spirometry and review.

**Thanking patients**
- Christmas card
- Thank you letter
- Discussed 'gift' idea – most don't give gifts. All felt the patients benefit from the long appointment and history taking.
- Paying for taxis to the surgery may well be appropriate if only way for the patient to get there.

**Keeping students active during the session**
One GP taught group of 6 (Weston) and split them into smaller groups and went between the two groups – OK for history taking – less good for examination.
Ask 1 student to summarise history after history taking.

| | |
|---|---|
| Student 1: | taking history |
| Student 2: | Commenting on process |
| Student 3: | Commenting on content |
| Student 4: | 1 sentence summary |

For year 2 – taking history in a circle – if one student gets stuck next one takes over. You can then start in different place for next patient.

GPs need to be aware of patient's needs which include follow up arrangements after the session. Often something new comes up and this can be an opportunity to organise tests and arrange review.

**Feedback**

- 2nd years: Individually given, considering how they have worked in the group, ensure you draw out the retiring student.
- Keep notes after each session.
- North Bristol Academy apparently send photos of students – can help you recognise and remember them. Might be useful for other academies to do.

**Erasmus students**

Generally felt that more information was needed on Erasmus students as we didn't know what to expect of them. Sarah looked into this.

Sarah Jahfar wrote the following summary about Erasmus students. This was also published in the May Teaching Newsletter

**ERASMUS students in Year 3**

The incoming Medical Erasmus students from Granada, Paris and Bordeaux arrive in September, stay for the whole year and study all year 3 units. Students from Vienna arrive in September and stay until January and only study Medicine and Surgery and the students from Grenoble arrive in January and stay until June and also only study Medicine and Surgery.

They are expected to do the same assessments as our home students bar the written exams in June. Students are expected to have conversational English to A-Level standard and they undertake medical English lessons alongside their studies (20 hours over the whole year).

**Training needs**

- All felt the workshops were good and improving
- Good to have balance of science and workshops.
- Year 3 handbooks good for Medicine and Surgery – less good for other areas.
- We must accept that we can't cover everything!

Melanie Blackman, May 2011

## Small group teaching using the one minute preceptor (OMP) method (peripheral neurological problem)

### Julia Vasant and David Little, teaching fellows from Bath Academy

We would like to thank Julia and their students for giving a demonstration how they teach history taking and examination of the peripheral nervous system using the OMP method. This method is suitable for all years. They also role played 'good feedback giving'

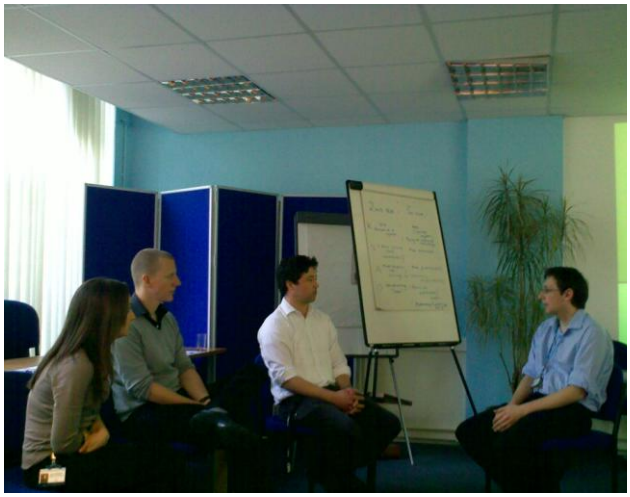
**The One Minute Preceptor (OMP) method**

The OMP model was designed to enhance teaching in ambulatory clinics in America. It could be used in General Practice in the UK where teaching is also characterised by variety, unpredictability, immediacy and time constraints.

1. Get a commitment – ask learner to articulate diagnosis, plan etc
2. Probe for supporting evidence – evaluate the learner's knowledge or reasoning
3. Teach general rules – common "take home points" that apply to future cases
4. Reinforce what was done well – positive feedback
5. Correct errors – constructive feedback


**Good feedback giving**

- Encourage self reflection
  - 'How did that go for you?'
- Positive first
- Be specific
- Comment on behaviour
- Offer suggestions how to improve



## Core Curriculum in Psychiatry

All doctors require core knowledge of psychiatry and psychology to be able to comprehensively assess and treat their patients. Assessment of an individual includes their entire health, including physical and mental health and social functioning. The core curriculum presented here is relevant for all doctors and should be supplemented by other components such as student selected components and the like to meet the needs of those with a greater interest in psychiatry. Areas of this curriculum may be covered at any stage in the undergraduate medical course. Many will be covered on a specific psychiatry clinical placement.
Tomorrow's Doctors (2009) presents three overarching outcomes for newly qualified doctors: The doctor as a scholar and a scientist; the doctor as a practitioner; the doctor as a professional. This curriculum maps onto these overarching outcomes and specific outcomes relevant to psychiatry.

**Principal aims** of the undergraduate medical course specific to teaching in clinical Psychiatry

- To provide students with knowledge of the main psychiatric disorders, the principles underlying modern psychiatric theory and commonly used treatments (The doctor as a scholar and a scientist).
- To assist students to develop the necessary skills to apply this knowledge in clinical situations (The doctor as a practitioner).
- To encourage students to develop the appropriate attitudes necessary to respond empathically to psychological distress in all medical settings (The doctor as a professional).

**Learning Outcomes**

### THE DOCTOR AS A SCHOLAR AND A SCIENTIST

**On completion of undergraduate training the successful student should be able to:**

1. Describe the prevalence and clinical presentation of common psychiatric conditions and how these may differ according to age and developmental stage.

2. Explain the biological, psychological and socio-cultural factors which may predispose to, precipitate or maintain psychiatric illness and describe multi-factorial aetiology.

3. Describe the current, common psychological and physical treatments for psychiatric conditions, including the indications for their use, their method of action and any unwanted effects.

4. State the doctor's duties and the patient's rights under the appropriate mental health legislation and mental capacity legislation.

5. Describe what may constitute risk to self (suicide, self harm and/or neglect, engaging in high risk behaviour) and risk to and from others (including knowledge of child protection and protection of vulnerable adults).

6. Summarise the major categories of psychiatric disorders, for example using ICD-10.

7. Describe the basic range of services and professionals involved in the care of people with mental illness and the role of self help, service user and carer groups in providing support to them. As part of this students should be able to describe when psychiatrists should intervene and when other clinicians should retain responsibility.

8. Describe the principles and application of the primary, secondary and tertiary prevention of mental illness.
9. Find, critically appraise and apply information and evidence gained from in depth reading relating to a specific clinical case.

## THE DOCTOR AS A PRACTITIONER

**On completion of the course the successful student will be able to:**

1. Take a full psychiatric history, carry out a mental state examination (including a cognitive assessment) and write up a case (as would be found in medical records). This includes being able to describe symptoms and mental state features, aetiological factors, differential diagnoses, a plan of management and assessment of prognosis.

2. Prescribe psychotropic medication safely, effectively and economically.

3. Provide immediate care in psychiatric emergencies, which may occur in psychiatric, general medical or other settings. In particular be able to conduct a risk assessment (risk to self and others), act appropriately based on this risk assessment, and to be competent in the management of acute behavioural disturbance.

4. Screen empathically for common mental health problems in non-psychiatric settings and recognise where medically unexplained physical symptoms may have psychological origins.

5. Communicate effectively with patients and multi-disciplinary colleagues. Discuss with patients and relatives the nature of their illness, management options and prognosis. Be able to communicate well and empathically with difficult, violent and/or mentally ill patients. Summarise and present a psychiatric case in an organised and coherent way to another professional.

6. Recognise the differences between mental health problems and the range of normal responses to stress and life events (including bereavement).

7. Plan which physical and psychosocial investigations should be carried out when patients present with psychiatric symptoms and when starting psychotropic medication.

8. Evaluate information about family relationships and their impact on an individual patient, which may involve gaining information from other sources.

9. Evaluate the impact of psychiatric illness on the individual and their family and those around them.

10. Assess a patient's capacity to make a particular decision in accordance with legal requirements and the GMC's guidance.

## THE DOCTOR AS A PROFESSIONAL

**On completion of the course the successful student will:**

1. Behave according to good ethical and legal principles, including, but not limited to, those laid down by the General Medical Council.

2. Recognise the importance of the development of a therapeutic relationship with patients, including the need for their active involvement in decisions about their care.

3. Act in a safe way towards patients. Understand the potential to do harm to psychiatric patients, including by providing untrained/unsupervised psychotherapeutic interventions and fostering inappropriate doctor-patient attachments.

4. View psychiatric patients as being as deserving of the same high standard of medical care as patients with purely physical illness. Demonstrate understanding of how patients' opportunities may be affected by stigmatization of psychiatric illness and show sensitivity to the concerns of patients and their families about such stigmatisation of psychiatric illness.

5. Recognise the importance of multidisciplinary teamwork in the field of mental illness in psychiatric, community and general medical settings, primary care settings and some non medical settings.
6. Reflect on how working in mental health settings may impact upon their own health and that of colleagues. Understand the importance of seeking professional help if they themselves develop mental health problems.

## Appendices

These outline in more detail specific aspects of the knowledge and skills that are referred to above and also to wider areas of knowledge and skills that should ideally be taught across the curriculum.

### Appendix 1 – Psychiatric Disorders and related topics

Knowledge of the following is a minimum:

- Simple classification of psychiatric disorders
- Anxiety disorders
- Mood disorders
- Psychosis and specifically schizophrenia
- Substance misuse, especially alcohol and cannabis (acute & chronic effects)
- Delirium
- Dementia
- Somatoform disorders
- Acute reactions to stress and PTSD
- Eating disorders
- Disorders of personality
- Effects of organic brain disease
- Patients who self harm
- Major disorders in childhood (including neurodevelopmental disorders) and differences in assesment
- Differences in presentation in older people
- Problems of those with Learning Disability
- Co-morbidity

### Appendix 2 – Basic Sciences

A good knowledge of neuroanatomy, neurophysiology, neurochemistry, neuropathology and psychology

- The function of the synapse, and the roles of different neurotransmitters
- Mechanisms underlying attention, perception, executive function, memory and learning
- Mechanisms relevant to the experience of emotion
- Human development (emotional, physical and social)
- Psychological concepts of health, illness and disease. Psychological factors that contribute to the onset and course of illness
- Psychological aspects of behaviour change and treatment compliance

### Appendix 3 – Psychopharmacology

- Function of the main neurotransmitter systems in the CNS.
- Basic neurochemical theories of depression, schizophrenia and dementia.
- Mechanism of action and clinical pharmacology of commonly used psychotropic drugs:
  - Anxiolytics
  - Antidepressants
  - Antipsychotics
  - Mood stabilisers
  - Drugs for dementia
- Mechanism of action of common psychoactive drugs used recreationally such as:
  - Alcohol
  - Cannabis
  - Stimulants

## Appendix 4 – Sociological and ethical issues

The meaning of 'illness' to individuals and society

- Awareness that different models of illness lead to varied responses to (and understanding of) psychiatric illness among individuals, groups and societies. As a minimum the following models need inclusion: biopsychosocial, multi-axial, medical, developmental and attributional models
- Ethics and the values that underpin core ethical principles
- Relevance of family, culture and society and the individual's relationship with these
- Importance of life events
- Stigma
- Outline the public health importance of mental health nationally and internationally in terms of personal, economic and social functioning, including a knowledge of prevalence, disability, chronicity, carer burden, cultural attitudes and differences, suicide, and service provision.

## Appendix 5 – Psychological treatments

Students should have an understanding of the principles of psychological management of common psychiatric disorders, especially those that are likely to be seen in primary care such as depression and anxiety. Students should know about common therapies, including cognitive behavioural therapy, interpersonal therapy, counseling, motivational interviewing.

Recognise the importance of lifestyle on mental health and its impact on treatments including sleep hygiene, nutrition, social interaction, fitness, activity, education, occupation, and family and community involvement.

## Appendix 6 – Communication skills

The following aspects of interview skills are important but often difficult for undergraduate students to fully attain. Observation and feedback on assessments is recommended.

- **Active listening**
- Empathic communication and building rapport
- Understanding non-verbal communication
- Skills in opening, containing and closing an interview

### Active listening

Listening is not the same as hearing. It is an active process of constructing meaning from what you are hearing. It is important to listen with empathy. By this we mean that you attempt to put yourself into the shoes of the speaker and 'hear' the emotions that are carried within what is being said.

<u>There are 3 key features</u>

**Comprehending**

This means that you understand and share the meaning in what the person is saying

**Retaining**

You need to remember what you heard to have an effective conversation.

**Responding**

Responses tell the speaker that they are being listened to and whether meaning is shared. We can respond in a variety of ways.

- Body language – nodding, leaning forward, maintaining eye contact
- Pre-verbal – 'Hmmm... .'
- Verbal
  - **Encouraging words** 'Go on'
  - **Reflecting back** 'So you said that your knee was hurting'
  - **Repeating** 'problem with the car…'
  - **Clarifying** 'When you said your knee was hurting did you mean that you couldn't move it'
  - **Paraphrasing** Patient 'I couldn't do a thing'
    Doctor 'So when you tried to get into the car you couldn't bend your knee'

## And here is your evaluation of the workshop

Thank you for taking the time to give us detailed feedback, much appreciated

**Section 1: Academy**

| **1.** Which Academy is your practice attached to? | | | |
|---|---|---|---|
| Bath: |  | 12.5% | 3 |
| Gloucester: |  | 16.7% | 4 |
| North Bristol: |  | 54.2% | 13 |
| South Bristol: |  | 12.5% | 3 |
| North Somerset: | | 0.0% | 0 |
| Somerset: |  | 4.2% | 1 |

| **2.** Which year/s are you teaching in? | | | |
|---|---|---|---|
| Year 2: |  | n/a | 8 |
| Year 3: |  | n/a | 15 |
| Other *(please specify)*: |  | n/a | 13 |

**2. Which year/s are you teaching in? Other, please specify:**

- Years 1-5 as a GP Tutor
- Yr 1, 4 and 5,
- 2, 4 and 5. 3 until this year,
- 4 and 5 x2
- 4x4
- But not both this year,
- Will be teaching year 3 when I start my Registrar year this August.
- Will start yr 3 in coming academic year,
- Yr 4 and Yr 5 OSCE Yr 3 Ethics Teaching Yr 5 Communication Skills session

**Section 2: Please rate the following workshop sessions:**

| **3.** Review and update of Years 2 & 3 | | | |
|---|---|---|---|
| Poor: | | 0.0% | 0 |
| Below average: | | 0.0% | 0 |
| Satisfactory: |  | 25.0% | 6 |
| Good: |  | 45.8% | 11 |
| Excellent: |  | 29.2% | 7 |

**3.a. Comment**

- Very stimulating and informative, also enjoyable!
- Not particularly useful to me as a Communications Skills tutor.
- useful info, clearly presented
- Too long? I have been teaching for several years now. This was more useful when I knew less about the teaching in Primary Care
- Only able to come to afternoon ( my colleague Mel mackintosh came in my place in the morning

| 4. Overview of Psychiatry teaching in Year 3 and discussion of Primary Care learning objectives in Psychiatry | | | |
|---|---|---|---|
| Poor: | | 0.0% | 0 |
| Below average: | | 0.0% | 0 |
| Satisfactory: |  | 29.2% | 7 |
| Good: |  | 45.8% | 11 |
| Excellent: |  | 25.0% | 6 |

**4.a. Comment**

- I was unaware of the contribution GPs give to the education of Med Students regarding Psychiatry. I have only ever taught Consultation skills. I was impressed. Much better than in my day.
- Interesting but again not very useful for me
- Useful to hear what was being taught in hospital.
- Learnt much more about how the course is organised centrally which will help in terms of organising the patients I get in.
- Very helpful to have an awareness of how different the medical student experience of psychiatry is now from when I was a medical student last century. Useful to discuss with other GPs how they had run Psychiatry teaching sessions
- Useful to hear how it's done
- Useful to hear what others do and get some good tips on future teaching. In particular, the value of patient narrative plus using the patient as an expert
- It was really useful to hear about students' experience in secondary care. Help inform my teaching plans to know.
- I didn't really learn anything

| 5. Teaching therapeutics -- workshop on prescribing SSRIs | | | |
|---|---|---|---|
| Poor: | | 0.0% | 0 |
| Below average: | | 0.0% | 0 |
| Satisfactory: |  | 20.8% | 5 |
| Good: |  | 25.0% | 6 |
| Excellent: |  | 54.2% | 13 |

**5.a. Comment**

- Very useful to have this depth of case
- Very good review of problems of using SSRIs. As a GP of many years standing most of this was known, but not why. Now I do.
- Really interesting stuff as a clinician.
- Some pharmacology too detailed and irrelevant for GP and year 3 teaching. No clear guidelines or conclusions from the session
- The pharmacology presentation on SSRIs was very interesting. Not quite what I expected, as not clear how the students are taught about this issue.
- Superb but scary.
- very useful but not what I expected in a session about yr 2/3 teaching
- Wasted on the students. Excellent for our clinical practice and for our teaching of course
- Interesting but not totally relevant
- Well run and interesting; almost too much to take in though!
- Interesting to be reminded the various pitfalls of SSRIs but scary!

- Lots of things I didn't know before

| 6. Top tips for teaching in Years 2 & 3 | | | |
|---|---|---|---|
| Poor: | | 0.0% | 0 |
| Below average: | | 0.0% | 0 |
| Satisfactory: |  | 25.0% | 6 |
| Good: |  | 66.7% | 16 |
| Excellent: |  | 8.3% | 2 |

**6.a. Comment**

- Yes this was very helpful, some new some old ideas. Very helpful to know what others are doing though there will always be some variation. Good to keep up standards
- Good small group work, and good plenary session
- Same thoughts
- I found the brainstorming group sessions really helpful, as someone who has not yet taught the psych element.
- Useful tips from everyone. Good discussion.
- I did not stay for the afternoon session
- Always good to hear how other teachers do it.
- really useful discussion with colleagues about a variety of topics including how to spot/ deal with the struggling student
- I can't really mark myself! I hope it was at least satisfactory!
- absent but had to mark or rejected

| 7. Small group teaching using the 'One Minute Preceptor' method (Bath Teaching Fellows) | | | |
|---|---|---|---|
| Poor: | | 0.0% | 0 |
| Below average: |  | 4.2% | 1 |
| Satisfactory: |  | 16.7% | 4 |
| Good: |  | 62.5% | 15 |
| Excellent: |  | 16.7% | 4 |

**7.a. Comment**

- I think we probably do this but useful to have feedback that specific pos and neg critique is very helpful
- I had another appointment that afternoon, and so, could not attend
- Useful method. good to have student feedback
- Interesting, but I felt the point was laboured quite a lot.
- Clear, good demonstration on neurological examination and how the technique works.
- Not present for this
- Must brush up on my own neuro examination skills!
- Mainly formalising what we were probably doing before
- OMP = another feedback style gimmick which I might use in certain settings
- Thought about using it more during the history taking in a teaching session, rather than when questioning about the diagnosis
- The title was actually more exciting than the method, which didn't really seem to be anything new.

| 8. Hippocrates and more | | | |
|---|---|---|---|
| Poor: | | 0.0% | 0 |
| Below average: | | 0.0% | 0 |
| Satisfactory: | | 37.5% | 9 |
| Good: | | 45.8% | 11 |
| Excellent: | | 16.7% | 4 |

**8.a. Comment**

- I will try and look into this site before my next session with them
- I had another appointment that afternoon, and so, could not attend
- Had to leave early but shall look up the website now I know about it. This is potentially useful. BTW the system insists I rate the workshop although I didn't attend it!
- Apologies, I stepped out and missed a lot of this.
- good overview of websites
- To know what resources we have - now to find time to look at it!
- Must look at Hippocrates
- Very useful for as many of us to know about these websites and learning tools as possible. Shame there isn't enough time in my life to take full advantage of all the resources!

| Section 3: The Workshop Overall |
|---|

| 9. Please rate the workshop overall: | | | |
|---|---|---|---|
| Poor: | | 0.0% | 0 |
| Below average: | | 0.0% | 0 |
| Satisfactory: | | 20.8% | 5 |
| Good: | | 41.7% | 10 |
| Excellent: | | 37.5% | 9 |

**9.a. Comment**

- Enjoyable day. I feel much more confident in delivering teaching, and knowing what is expected.

**10. What did you enjoy & find most useful at this workshop? Why?**

- Enjoyed the session with the psychiatrist and learnt a lot
- I enjoyed it all, very helpful to have specialist and also med student input and to know what happens elsewhere
- Always an excellent forum to share experiences of teaching and get tips on how you may be able to improve your teaching sessions with undergraduates Good to have some student involvement in the day
- Learning about GP involvement at this level.
- The pharmacology lecture. New information, better understanding or interactions and adverse effects.
- The top tips & how to give feedback.
- Teaching tips sessions and discussing how others do their teaching and the challenges they face
- I like the group sessions, learning how other GPs teach.
- SSRI prescribing most useful.
- the teaching on prescribing SSRIs and chance to have a small group discussion about teaching with a psychiatrist
- Psychiatry - all aspects.
- Having protected time to reflect on teaching and share with colleagues
- Top tips, as ever
- As usual, meeting and discussing teaching with colleagues informally. The formal teaching session on therapeutics was excellent. Other sessions good but to some extent repeating what has been said at previous workshops
- meeting colleagues; those who teach always seem a nice bunch and I get ideas for my own teaching
- Thought about using it more during the history taking in a teaching session, rather than when questioning about the diagnosis
- The SSRI talk was useful and very interesting.
- Good discussion groups. v good talk on SSRIs.
- teaching psychiatry and SSRI talk, as new stuff I hadn't known before
- Hearing more about SSRI cautions and interactions
- I found the small group session on teaching psychiatry the most useful

**11. What suggestions do you have for improvement to this workshop? What teaching topics would you like for future workshops?**

- Nil - well organised and enjoyable
- I think this kind of mix is just right. Some bread and butter teaching theory and application (ok to use old ideas again, they still work!!) and some challenging sessions
- Keep the good balance of interactive sessions and 'talks' in the day
- It was good focusing on one subject, perhaps focusing on other subjects in turn?
- When advertising in the future make it clear it's only for those GPs who have students in their practice. I'd not understood what you mean by a GP teacher, and that I'm not one!!
- I would have preferred to attend the workshop tailored for GP Registrars. Nevertheless, I'm glad I've attended this to get a flavour of how things could be like.
- More practical sessions with the hosp teachers as it is good to know what the students are doing in hospital
- If the talks from psych could be made more relevant to what or how we should be teaching the students, this would be more applicable to the day's tasks.
- orthopaedics again please

- Musculoskeletal teaching
- More system- based teaching tips
- Another one on teaching long-term conditions would be good
- Working through the various systems we have to teach on.
- Perhaps look at how to help / spot the strugglers! I feel we are getting more confident in our teaching and would be ready to take on this most difficult task
- More primary-secondary care teaching collaboration, so that GP's continue to get an insight into the students' curriculum.
- Carry on as it is, very good
- I would suggest some very basic teaching on mental start examination
- some more practice on using the calgary-cambridge goldfish bowl teaching style

**12. Any other comments?**

- Thanks
- Very nice, well run course. I picked up a couple of useful hints e.g. warning that I might be asking for a summary at any time of any student
- Thank you very much.
- I know this was already stated - avoid school holidays for future workshops and more notice? I have had to rate sessions I did not attend - offer an option for this with the next survey?
- You will never get the best day for everyone, but contrary to comments made during the day, holding this session in the school holiday made it easier for me to be there (No need rush off at 3:15 to do a school pick-up)
- This is the second time I have been asked to fill this form and second time I have completed it
- It was useful to have the day divided in half with yr 3 in am and yr 2 in pm so that I could share attendance with my colleague

- Always enjoy attending and learning new teaching ideas