Report of the Royal College of Psychiatrists' Scoping Group on Undergraduate Education in Psychiatry

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Incorporating feedback from the ETSC

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1 Acknowledgements

As Chair Nisha Dogra would like to thank everyone who contributed to the work of the Scoping Group and the support they provided. She would especially like to thank Simon Budd, Steven Cooper, Subodh Dave and Teifion Davies and Suzanne Hardy for their support to her as Chair.

This report has been prepared by Nisha Dogra but all members of the Scoping Group have had the opportunity to review and comment on the document.

1 Background

Psychiatry is an essential component of undergraduate medical education as doctors in all specialities will encounter patients affected by mental health problems, and all doctors should be able to recognize and initiate management of mental disorder. However, recent surveys of student attitudes to psychiatry had found several negative views of undergraduate psychiatry courses and of postgraduate psychiatry careers. In addition, a survey of all UK and Ireland medical schools commissioned by the Association of University Teachers of Psychiatry in 2005 found great variations in the content and delivery of undergraduate psychiatry curricula (Karim et al in press). The research also found that psychiatric teachers often felt that psychiatry was stigmatised by students and faculty and this remained a significant problem. Finally, the Royal College of Psychiatrists was increasingly concerned that the experience of learning psychiatry amongst medical students was having a negative effect on entry into postgraduate psychiatry training.

The Royal College of Psychiatrists scoping group on undergraduate psychiatric medical education was established in 2006 at the instigation of Professor Dinesh Bhugra, then Dean of the Royal College, to explore these issues and make recommendations on the content and delivery of undergraduate psychiatry courses, and on the promotion of psychiatry as a career.

2 Membership

Membership of the group consisted of:
Dr Simon Budd, Honorary senior clinical lecturer, University of Leeds,
Professor Stephen Cooper, Professor of Psychiatry, Queens University, Belfast,
Vivek Datta, Medical Student
Dr Subodh Dave, Teaching fellow and consultant psychiatrist, Nottingham/Derby University
Dr Richard Day, Senior lecturer in psychiatry, University of Dundee,
Dr Teifion Davies, Senior lecturer in community psychiatry, Kings College London.
Dr Nisha Dogra, Senior lecturer in child and adolescent psychiatry, University of Leicester (Chair of Group)
Michael Eyre Medical Student
Suzanne Hardy, Senior advisor, HEA subject centre for Medicine, dentistry and Veterinary Medicine.
Dr Brian Lunn, Senior lecturer in psychiatry. University of Newcastle,
Tom Pollack, Medical Student
Dr Barry Wright, Honorary senior lecturer in child and adolescent psychiatry, University of York

Administrative support:
February 2007- June 2008 Lucy Bailey
August 2007- November 2009 Dela Goka

The group were joined on an ad hoc basis by
Dr Lisetta Lovett, Senior Lecturer in Psychiatry (University of Keele), Professor David Cottrell, and Professor Allan House (University of Leeds)

Dr Paul Courtney and Dr David Dayson from Royal South Hants Hospital, Southampton. Matthew Mak was also invited from the BMA student committee and attended one meeting. The BMA medical student committee did not send any further representatives. Fiona Brown was nominated as the GMC lead but has not to date attended any meetings. Minutes of the meeting are also sent to Katie Hillman, Kate Holliday and Sally Pidd. In this way we were able to ensure that the work of the scoping group was disseminated to other relevant College groups.

3 Meetings

The scoping group as a whole met on:
16th February 2007(London),
25th April 2007 (Leeds),
8th June 2007 (London),
23rd August 2007 (London)
8th November 2007 (London)
10th April 2008 (London)
5th November 2008 (Birmingham).

The subgroups also met in between these dates to meet their remits.

The minutes of the meetings are available from Dela Goka and Nisha Dogra if required. There are no minutes available for the meeting in June 2007 as Lucy Bailey took the minutes at the meeting but did not produce any before leaving the Royal College in July 2007.

4 Accountability and remit

The scoping group was accountable through Professor Bhugra to the Education Training and Standards Committee. The remit of the Scoping Group was discussed and agreed over the first two meetings. Approval for the remit was sought and obtained from Professor Bhugra who had commissioned the group and Professor Hollins in the context of the Presidential campaign on Images of Psychiatry. It was agreed the scoping group would:

1. Develop a core curriculum for undergraduate curriculum and provide guidance on how to deliver and assess this curriculum
2. Identify best practice documents about financial clarity and Trust management of education (including how clinical staff are expected to fulfil their teaching commitments)
3. Best practice guides for clinical teachers (to develop support and ideas for the delivery of quality teaching) and;
4. Develop material that would support the promotion of psychiatry to medical students. This would cover what students can contribute to their placement and what they find can help their teachers to provide engaging, effective and educational placements.

This is turn has led to a series of projects and sub-groups which are now reported on in turn

5 Curricular support

5.1 Core curriculum

Team comprised of Stephen Cooper, Nisha Dogra, Brian Lunn and Barry Wright.

There is now a core curriculum that was developed by a subgroup. Consultation took place with the wider Scoping Group, psychiatric leads not on the Scoping Group, key College personnel, members of the College (invited via the e- bulletin) and key academic general practitioners who have expertise in teaching mental health to students. We did not secure funds to undertake further work using the Delphi technique. Despite this we are confident that through the wide consultation we have met our goal of developing a core curriculum that is acceptable and rooted in the evidence base available. The General Medical Council is including the core curriculum document in their list of useful references to be included in the consultation for the review of Tomorrow's Doctors. The core curriculum is presented as Appendix One. The core curriculum is already being used as a basis for medical school curricula in the UK (e.g. Leeds and Warwick).

5.2 Integrating psychiatry

Team comprised of Teifion Davies and Richard Day

This work explored where psychiatrists might opportunistically and strategically include psychiatric teaching throughout the curriculum, as well as influencing curriculum delivery in other ways.
Appendix Two shows a summary of this work.

5.3 Student attitudes towards psychiatry

Team comprised of Simon Budd, Ian Collings (Cardiff) Stephen Cooper, Richard Day, Nisha Dogra and Rachael Lilley (research associate)

This was an LTSN funded project to explore student views of psychiatry. This is based on some earlier work undertaken by Simon Budd and colleagues at Leeds. We have modified and expanded the questionnaire to include a larger UK sample to enable a broader picture of student perspectives to be gained. We collected from Leeds, Dundee, Belfast and Cardiff medical schools with a sample size of just under 1000. Analysis is still taking place but early indications are that (we have avoided giving numbers as we still have data of about 350 students to enter)

- 14% of students rated psychiatry in their top three choices
- Job satisfaction, family friendliness and academic challenge are important factors in making career choices with earning potential and status being less important.
- Only 30% felt there was sufficient opportunity for careers advice
- Majority had a positive experience on their clinical placement
- A small minority were more negative about psychiatry after their placement.

- Most thought psychiatrists derived a lot of job satisfaction from their work
- A small number thought their clinical placement needed to be shorter
- Majority thought they had enough direct clinical exposure
- Most thought the teaching was relevant for their work as foundation doctors
- A significant number experienced difficulties with patients and felt uncomfortable on their placements
- Majority felt they had the opportunity to receive feedback
- Majority felt part of the clinical team.
- Despite fairly positive experiences most were still unlikely to pursue a career in psychiatry.

The work is being prepared for peer reviewed publication. The findings should help us to further establish what the more effective methods are for promoting psychiatry as a subject for medical students. A Swedish group has used the same questionnaire as designed by this team and collected data for over 700 students. We hope to be able to compare the data to identify if the issues are UK specific or more of an international trend.

5.4 Student website to promote psychiatry as a career

Team comprised of Guy Brookes (Leeds), Nick Brindle (Leeds) and Nisha Dogra. They were latterly joined by Clare Oakley (Chair of Psychiatric Trainees' Committee). There was input to the content from a wide range of personnel including medical students. The site was developed by Sheilen Rathod at Reluctant Hero.

This was an Images of psychiatry funded project to develop a website to promote psychiatry to medical students in the first instance. Part of this came from what students at various medical schools are telling us in terms of the lack of promotion of psychiatry as a career. Another identified issue is how to establish career leads at each medical school to ensure that students who are interested in psychiatry have the opportunity to discuss this with a formal careers structure although we also anticipate that consultants can be informally approached.

The website aimed to:
The aim of the site is to promote psychiatry as a career to (primarily) medical students and (secondarily phase 2) to FY1 and FY2 doctors and A level students. The site aimed to:

- Show psychiatry as an interesting, challenging and diverse career choice
- Dispel some of the myths and show psychiatry to be a 21st century science.
- Encourage medical students to want to learn more about the profession, and
- Provide them with the opportunity to read more, or download detailed information and give them the means to contact the relevant people / person within their faculty.

The site was developed and went live on 1st December 2008 and handed over
To Robert Howard, Dean of the College.

5.5 Financial clarity and best practice

Team comprised of Subodh Dave, Nisha Dogra & Stuart Laesk (Nottingham)

Subodh Dave led the subgroup which looked at financial clarity and Trust management of education as there is huge variability in what happens right across the country. Although the new universities have tended to have more open and transparent arrangements, it is unlikely that we can produce a document that will gain the support of the variety of stakeholders. To prevent being prescriptive we are suggesting that it would be useful to have a variety of approaches and be able to describe the advantages and disadvantages of each so that at least people are aware of the possibilities of their particular approach. Professor Weetman, of Council of Heads of Medical School reviewed the documents produced. A paper has been submitted to Psychiatric Bulletin.

Key recommendations were that quality assurance is the cornerstone of improved educational governance and focusing on achieving this may help. Attention also needs to be paid to robust leadership and greater transparency.

Quality Assurance

- Creating transparent financial and managerial structures is absolutely necessary to ensure that SIFT expenditure is used appropriately. Trusts could be penalised for not having clarity or transparency as not to have these is poor clinical governance in terms of accountability
- SIFT funds should be ring fenced for medical student education or linked to actual medical student teaching activity.
- Procedures should be established so that an audit trail can be maintained to demonstrate that SIFT funds are spent directly on medical education.
- Medical student teaching needs to be explicitly identified in consultant job plans

Robust Leadership

- Medical education leads have a crucial role to play in liaising with SIFT providers, trust management and various colleagues who will help deliver clinical teaching to medical students.

- Strong leadership is needed to ensure that psychiatry does not lose out to more technical disciplines such as surgery. (Dave, Dogra and Laesk submitted)

6 Support for clinical teachers

6.1 Survey of clinical teachers

Team comprised of Nisha Dogra, Roger Bloor (Keele), Shamama Mir (Keele), Ravi Belgamwar (Keele) & Subodh Dave.
In terms of providing support for clinical teachers we undertook a questionnaire survey of the views of clinical psychiatric teachers regarding education at Leicester, Derby and Keele medical schools. Response rates were low but there were fifty-five returns. Key findings were that:

- Majority of respondents enjoyed teaching although it is possible that only those who do enjoy it responded to the questionnaire thus biasing the sample.
- Most usually had the time to teach in clinic but this was less often the case on the wards.
- Only 15 (27.3%) felt there was a clear contractual agreement to teach.
- More respondents felt the medical school valued them as a teacher whereas fewer respondents felt valued as teachers by Trusts although neither rated well for valuing staff
- Most respondents did not feel that there were any financial rewards for teaching.
- The numbers who felt there were non financial rewards were small but again more felt the medical schools were better than Trusts at rewarding teaching.
- More than a third of the respondents felt they had opportunities to contribute to the development of the curriculum but nearly half still said that greater opportunities to do this would make teaching a more rewarding experience.
- Unsurprisingly most respondents wanted more time to teach and the findings suggest that contracted and protected time may help improve the experience of teaching.

This work will be written up as a short report and the questionnaire modified for future use.

6.2 Clinical teaching in psychiatry workshops

Team: Nisha Dogra & Subodh Dave

This was a workshop supported by the Higher Education Academy. It was piloted in derby in May 2008 and will be run nationally on 2nd April 2009. The subjective delegate feedback was generally positive. A summary of the workshop is presented in Appendix Three

6.3 Setting standards for clinical teachers

Team comprised of Nisha Dogra, Simon Budd, Peter Yeates (Manchester) & Roger Barton (Newcastle)

Appendix Four presents a draft document based on initial work. This project is ongoing but we can make some recommendations at this stage which are included in the final recommendations.

6.4 The Role of the Association of University Teachers in Psychiatry (AUTP)

Supporting clinical teachers is a strand that the AUTP hopes to take forward. We are also aiming to develop a website in which we can include support for teachers in terms of advice about the modules that exist such as special study skills modules. Information to be available about courses that support educational development and development of teaching skills. Wherever possible we would avoid replicating work that linked them to websites providing this information. The advantage of having it on a single website is that teachers would know that the college is working to support them in this critical role. We have emailed all leads in psychiatry as well as the lead primary contact at all medical schools to collate information about Special Study Modules that are available as we hope to encourage others to use the work that has already been done to set up more SSMs.

6.5 Working with general practitioners to teach psychiatry

Team comprised of Dr Catherine Thompson (Specialist Registrar in the West Midlands) , Nisha Dogra and Professor Robert McKinley (Professor of Academic General Practice, University of Keele).
As another Images of Psychiatry funded project, Dr Catherine Thompson, undertook a project to investigate GP attitudes towards psychiatry and their views about teaching psychiatry. GP attitudes psychiatry were generally positive and a majority felt that psychiatry could be taught jointly by GPS and psychiatrists. This project is being written up for submission to peer reviewed journals.

7 Outcomes of the Scoping Group

1. A core curriculum document which the General Medical Council is including as part of a consultation on Tomorrow's Doctors in 2009
2. Paper on the financing of undergraduate education in psychiatry submitted to Psychiatric Bulletin
3. Presentation of the process of the Scoping Group at Association for the Study of Medical Education Annual Meeting, 11th September 2008.
4. Papers being prepared for peer reviewed publication from student survey
5. Ongoing research into Setting standards
6. Clinical teaching in psychiatry (workshops on 23rd May 2008 and 2nd April 2009)
7. A national meeting entitled Teaching and Learning in Undergraduate Psychiatry

A timetable of the Teaching and Learning in Undergraduate Psychiatry meeting is attached as Appendix Five. This meeting was run with support from the Higher Education Academy Subject Centre for Medicine. Presentations from the meeting are available on www.medev.ac.uk where consent was given for the information to be shared. Eighty people attended for one or both of the days. Of the 29 feedback sheets that were returned, 22 rated the meeting as good or excellent,

five as satisfactory, one as poor and one respondent rated it in between poor and satisfactory. The latter two respondents both felt that there was too much emphasis on the promotion of psychiatry to medical students as opposed to the actual teaching of psychiatry. The key areas of dissatisfaction were the pre conference planning and the venue. However, these had been anticipated but the need to not make a loss had to be borne in mind. However, most delegates did find the meeting useful, enjoyable and a good opportunity to meet others (although more time for networking would have been useful). A key part of the meeting was a workshop to explore where and how delegates felt we might take up some of the issues that had arisen in part from the work of the Scoping Group.

There was overwhelming agreement that an annual event perhaps in conjunction with the AUTP annual meeting would be valued. However a nice venue with more time for networking is required. More time needed but paradoxically one day event preferred. There was also agreement that it would be useful to be able to share resources through the web. There was less clear consensus on the agenda for medical education research although setting standards for clinical teachers was highlighted by one group. There was also less consensus on the need for a medical education research forum.

8 Recommendations from meeting on 5-6th November 2008

Nisha Dogra to explore the possibility of a Special Interest Group in Medical Education

There was consensus from those at the final workshop that a Medical education forum would be useful to provide support to teachers

There is a need for the College to more explicitly demonstrate that it values those that deliver teaching.

9 Other recommendations

Curricular

- Piloting of the core curriculum
- Sharing of good practice

Financial clarity

- Requirement of greater transparency and quality assurance
- Robust leadership

Promotion of psychiatry to medical students

- Website needs to be further developed and promoted
- Need better careers support frameworks in place

Supporting clinical teachers

- There needs to be a review of accredited short courses as the quality is variable and may not equip clinical staff to undertake their role of clinical teaching.
- A need to develop quality short courses that are specifically for clinical teachers
- Sharing of good practice through meetings and website resources

10 Summary

In summary the Scoping Group set out to:

- Develop a core curriculum for undergraduate curriculum and provide guidance on how to deliver and assess this curriculum
- Identify best practice documents about financial clarity and Trust management of education
- To develop support and ideas for the delivery of quality teaching and;
- Develop material that would support the promotion of psychiatry to medical students.

The Scoping Group has delivered on all these remits. There is a clear platform from which to develop further work.

11 Appendix one: Core curriculum in psychiatry

In formulating this we must recognise the variations between medical schools in the amount of time allocated to, and integration between, 'core' teaching in Psychiatry (usually in the 3rd or 4th Year of the undergraduate programme) and what is taught on what might be termed 'related' topics' (often in other Years), such as Psychology, Psychopharmacology and Communication skills. Some schools have considerable 'vertical integration' of aspects of Psychiatry throughout the curriculum but for others Psychiatry appears mainly in one block. The purpose of this proposed curriculum is to outline what are the key aspects of knowledge, skills and attitudes related specifically to Psychiatry that medical students require for basic competence and to meet the standards of 'Tomorrow's Doctors'. This forms the basis for subsequent training through the Foundation Programme and into Speciality Training in whatever area. Students must recognise that assessment of an individual includes their entire health and requires assessment to include physical and mental health and social functioning. The psychiatry clinical placement focuses on mental health.

We are also aware that high quality teaching that is relevant to the future needs of medical students is one of the most influential factors in promoting psychiatry as an exciting medical discipline. 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.

Specific to teaching in clinical Psychiatry, the principal **aims** of the undergraduate medical course should be:

- To provide students with knowledge of the main psychiatric disorders, the principles underlying modern psychiatric theory, commonly used treatments and a basis on which to continue to develop this knowledge.
- To assist students to develop the necessary skills to apply this knowledge in clinical situations.
- To encourage students to develop the appropriate attitudes necessary to respond empathically to psychological distress in all medical settings.

The **Learning Outcomes** are:

KNOWLEDGE

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, adults with learning disabilities and elder protection requirements)

6. Describe how to assess and manage psychiatric emergencies, which may occur in psychiatric, general medical or other settings. In particular be able to describe the elements of a risk assessment and the management of behavioural disturbance.

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

8. 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.

SKILLS

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

1. Take a full psychiatric history, assess the mental state (including a cognitive assessment) and write up a case. This includes being able to describe symptoms and mental state features, aetiological factors, differential diagnoses, a plan of management and assessment of prognosis.

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

3. Evaluate and describe patients presenting with abnormal fears/anxieties, pathological mood states and problematic, challenging or unusual behaviours.

4. Summarise and present a psychiatric case in an organised and coherent way to another professional and be able to discuss management with doctors or other staff involved in a patient's care.

5. Recognise the differences between mental health problems and the range of normal responses to stress and life events.

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

7. Assess a patient's potential risk to themselves and others, at any stage of their illness, and in particular be able to assess a patient following an episode of deliberate self-harm.

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

9. Find, appraise and apply information and evidence gained from in depth reading relating to a specific clinical case.

10. Discuss with patients and relatives the nature of their illness, management options and prognosis.

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

1. Utilise an empathic interviewing style, which is suitable for eliciting information from disturbed and distressed patients.

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. Demonstrate sensitivity to the concerns of patients and their families about the stigmatisation of psychiatric illness.

4. 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.

5. Demonstrate awareness of capacity, consent and confidentiality issues as they apply in Psychiatry.

6. Reflect on their own attitudes to patients with mental health problems and how these might influence their approach to such patients.

7. Reflect on how working in mental health settings may impact upon their own health and that of colleagues.

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 – Brain function
This will include aspects of neuroanatomy, physiology and psychology.

- Physiology of neuronal function
- Mechanisms underlying attention, perception, executive function, memory and learning
- Mechanisms relevant to the experience of emotion
- Mechanisms related to psychological function
- Human development and life cycle

Appendix 2 – Sociological issues

- The meaning of 'illness' to individuals and society
- Awareness that different models of illness (and the competing claims made for each of the models promoted by various groups) are important to the understanding of psychiatric illness, its symptoms and associated behaviours. As a minimum students the following models need inclusion: biopsychosocial, multi-axial, medical, developmental and attributional models as they relate to mental health problems
- Ethics and the values that underpin core ethical principles
- The law and mental health and capacity
- 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 3 – 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 and differences in assessment

- Differences in presentation in older people
- Problems of those with Learning Disability
- Co-morbidity

The degree to which a student may have clinical exposure to individual disorders will depend on the time allocated within the curriculum and the nature of the clinical experience available. It will not always be the case that exposure takes place in the setting of the psychiatric clinical attachment.

Appendix 4 – 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

Safe prescription of psychotropic drugs, including those with abuse potential.

Appendix 5 – Psychological treatments

In understanding psychological treatments, students should have an understanding on 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.

Approaches to common conditions include cognitive behavioural therapy, counselling, 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

Appendix 7 – Delivery of the curriculum

Delivery of the curriculum will depend on local resources, support and history and will need to involve many different teaching methods. During the clinical attachment, it is important to ensure that contact time with consultants is effectively used as there may be very little of this. It is also important that consultant psychiatrists are a visible component of the student experience. Students need any teaching to be made relevant to practice (Dogra, 2004) and there are benefits from seeing senior clinicians interested in their educational experience (especially for recruitment to psychiatry). Attention needs to be paid to consider what learning outcomes are expected to be achieved in different parts of the attachment. It is also important to ensure that where observation is used as a learning experience it is of little value without any adequate follow up. A ward round or clinic in which observation alone is used is unlikely to successfully help in meeting the learning outcomes outlined. Teaching should, where possible and appropriate, be delivered in the clinical settings where patients present and include professionals involved in their care.

Appendix 8 – Assessment

"Assessment drives learning" is a frequently quoted aphorism. It should also be recognised that assessment confers value to a course. For psychiatry to be recognised as a valuable element of undergraduate medicine assessment has to be robust and included in the terminal assessment of the whole undergraduate medical course.

Two elements are key to undergraduate assessment in psychiatry. These are formative and summative assessment:

- Formative assessment provides information for students about where they are in their learning process and what they need to do to reach their learning objectives. Ideally students should be directly observed interviewing patients and feedback given on their clinical skills. Additionally through case presentations assessment can be made of students' progress in attaining required knowledge outcomes. It is also notable that through a continuing process that attitudes can be assessed and, if required, challenged.
- Summative assessment needs to be directly related to the specified learning outcomes for each course. It should be at the end point of a student's learning in psychiatry. Into each assessment there needs to be components that address knowledge, skills and attitudes. For each of these areas differing assessment methods are indicated and assessors need to be clear about what objectives they are assessing in each component.

Clinical skills may be assessed using real patients or role players in a variety of objectively driven examination formats. It is important that the complexity of the cases is appropriate for the students' level of experience. Direct observation of students is the best means to assess clinical skills. Ideally cases should allow students at the end of their courses to demonstrate higher level skills such as

synthesis of multiple sources and types of information and clinical application of knowledge.

Stephen Cooper
Nisha Dogra
Brian Lunn
Barry Wright

12 Appendix two: Integration of Psychiatry into the Undergraduate Medical Curriculum

TEIFION DAVIES & RICHARD DAY

I TO INTEGRATE OR NOT TO INTEGRATE?
Teifion Davies

There are two major, and rather polarized, perspectives on the mode or method of psychiatry teaching and learning in the undergraduate curriculum:

- Integration
- Specialisation

To a considerable extent these map onto the two major aims of an undergraduate psychiatry course:

- To promote psychiatric knowledge, skills and appropriate attitudes in all medical graduates
- To promote psychiatry as a career, especially for the best medical graduates.

The former tends to be favoured by integrationists, who see specialisation as unappealing to the majority of undergraduates and therefore a poor preparation for general medical practice. The latter is favoured by specialisationists, who view integration as dumbing-down the curriculum and devaluing psychiatry as a discipline.

Evidence[1] suggests that graduates of medical schools where there is a positive experience of undergraduate psychiatry may be more likely to enter careers in psychiatry, while a negative experience has an exaggerated deterrent effect. This appears to be related to a number of rather vague characteristics:

- visibility of psychiatrists in teaching
- welcome received in psychiatry placements
- "acceptability" of psychiatrists
- Stigmatising views of psychiatrists by other doctors.

What puts students off psychiatry?

- Negative views of subject (unscientific, ineffective, neurology without physical signs, social work done by doctors)
- Negative views of psychiatrists (eccentric, unable to do real medicine, ineffective)
- Negative views of patients (dangerous, dirty, disabled and depressing).

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[1] Goldacre MJ et al. *Medical education* 2004;**38**: 249-258

II INTEGRATION – A PROGRAMME FOR ACTION
Teifion Davies & Richard Day

Integration of psychiatry into the undergraduate medical course is not about integrating the subject matter, but the psychiatrists.

Integration means involvement – All over the course "like a rash"

The Table shows some of the levels at which *psychiatrists* can integrate themselves into the delivery of the medical course. This is arduous and requires a team effort at each medical school. However, this level of involvement in the medical course provides the best opportunity to present a positive view of psychiatry and challenge the negative views.

Each of the examples in the Table is in use in a UK medical school.

The Table incorporates suggestions from several members of the Scoping Group especially Simon Budd.

Stage of student career	Intervention	Rationale
Pre-university	Take part in any recruiting events at schools; guest lectures on A-level courses	High visibility strategy; confront stigma early; show psychiatrists as doctors
Pre-application	Involvement in pre-medical school taster courses and summer schools for sixth formers	De-stigmatising; promotes speciality; raises profiles with schools and students
Pre-application	Contribute to content & design of medical school prospectus	Attract candidates with psychological bias
Short-listing for selection	Member of selection panel	Influence admissions policy; ensure those with attributes associated with psychiatric career are considered
Selection procedures (interviewing)	Interview candidates	Evidence on interviewing shows non-objective factors important (like-attracts-like effect)
Arrival at medical school	Contribute to introductory programmes and induction courses	High visibility at time when curiosity greatest; normalizes psychiatry as a branch of medicine

Stage of student career	Intervention	Rationale
Basic medical sciences	Contribute to neuroscience courses: everything from single slides to full lectures/tutorials	Give examples of the strong scientific basis of psychiatry, challenge unscientific views
Early clinical contacts	Offer early "taster" contacts with patients	Destigmatising if carefully organized
Psychology, sociology and humanities courses	Contribute everything from single slides to full lectures/tutorials	Demonstrate the breadth of psychiatry's roots
Intercalated BSc/BMedSci	Offer/contribute to wide range of degree courses	Raise intellectual curiosity
Clinical studies 1	Teach basic mental health evaluations skills early	Promotes basic skill learning, mental health assessment as part of routine assessment
Clinical studies 2	Encourage SHOs to teach basic medical skills (e.g. blood pressure, cranial nerves)	Reinforces "doctor" image of psychiatrist; attracts students
Clinical studies 3	Provide wide range of interesting, relevant placements	No more nodding off in ward rounds seeing the 100th patient with schizophrenia
Clinical studies 4	Ensure all placements are well organized and welcoming	Students report poor or negative experiences in some clinical settings
Clinical studies 5	Ensure all regular placements show psychiatrists in realistic but positive light	Students are very sensitive to deskilling of doctors in some clinical settings
Clinical studies 6	Ensure all regular placements show psychiatric treatments in realistic but positive light	Students often believe psychiatric treatments are ineffective
Clinical studies 7	Provide some high interest visits or placements	Prisons, special hospitals; risk of "zoo" effect so needs careful management
Clinical studies 8	Encourage patients to take part in teaching (as trained/paid educators)	Confront/combat stigma; show patients as ordinary people

Stage of student career	Intervention	Rationale
Clinical studies 9	Contribute to pharmacology/therapeutics teaching	High profile topics, good access route to reinforce psychiatric knowledge
Clinical studies 10	Curriculum design & delivery: spread psychiatry through the course	Pearls on a thread[2]. Students refresh and revise their knowledge rather than leave it behind
Interprofessional education	Mental health is ideal multidisciplinary learning environment	Can be unpopular with medical students, so needs careful management; will appeal to some
SSCs/SSMs	Provide psychiatric research studies	Popular with students; encourage keen students; reinforce scientific aspects
Electives	Provide advice and overseas contacts for psychiatry electives	Electives leave a glowing memory and often confirm a career choice
Revision (pre-Finals)	Provide revision courses, lectures and tutorials	Good “send off”, lasting message
Examinations and assessments	Contribute questions, OSCEs, examiners to every exam at all levels	Students only learn what is examined; a bit macho but true
Career selection	Participate in careers fairs; other formats include “Speed-dating” and “Job idol” where students meet psychiatrists from various sub-specialities	Students respond to the “real life” aspects of the subject; evidence that work-life balance in psychiatry attracts students
All stages	Personal tutor/mentor	Students see psychiatrists as approachable/dependable/effective role model
All stages	Provide lots of high-value prizes	Having a psychiatry prize on the CV is a potent reminder of the subject
All stages	Promote student psychiatry clubs or groups; invite well-known or controversial speakers	Ideal vehicle for promoting interest amongst high-flying students
All stages	Attractive, accessible online learning materials	Students learn in various ways, and increasingly rely on online learning; any subject not represented is viewed negatively

[2] The Bhagavad Gita

Stage of student career	Intervention	Rationale
All stages	Provide lots of self-test questions (papers, online)	Students love to test themselves, and need practice for exams; reinforce psychiatric knowledge at same time
Medical curriculum in general	Keep a close eye on developments in other topics; what do students like, and respond to?	What works for one subject might work for another; also important not to develop “silo” mentality but see psychiatry as part of the medical course
Medical education in general	Active involvement in, and management of, all aspects of medical school teaching and learning	The more you put in, the more you (and psychiatry) get out

13 Appendix three: Clinical Teaching in Psychiatry

The nature of clinical environment means that clinicians may often be unable to plan or prepare their clinical teaching. However, there are still steps that can be taken to maximise the valuable teaching opportunities that arise in clinical settings. This workshop will help clinical teachers consider their role in maximising the benefit of clinical exposure that students experience.

Learning objectives for workshop:
Evaluate the advantages and disadvantages of the strategies used by you in clinical settings
Identify your individual strengths and weaknesses for teaching through identifying your own learning preferences
Reflect on whether the strategies you use are the most effective.

Plan for workshop:
Group discussion regarding different settings for clinical teaching (20 minutes)
Individual exercise to consider the strategies used and the advantages and disadvantages of these (20 minutes)
Discussion in small groups (20 minutes)
Sharing different strategies (feedback to large group 45 minutes)
Complete learning styles questionnaire (20 minutes)
Discussion in small groups of how our own learning styles influence our teaching styles and preferences (20 minutes)
Discussion in large group of how learning styles influence teaching (30 minutes)
Reflection (10 minutes)
Small group work to develop action plan for changes that will be made on return to work (30 minutes)
Following up on the action plan (30 minutes)
Discussion (30 minutes)
Summary and feedback 10 minutes

Total time for workshop planned is 4 hours and 45 minutes

Timetable
10-10.30 Coffee/tea and registration
10.30-11.45 Session 1
11.45-12.00 Break
12.00-1.00 Session 2
1.00-2.00 Lunch
2-3.15 Session 3
3.15-3.35 Break
3.30-4.30 Session 4

14 Appendix four: Draft Setting standards for clinical teachers

Background
This draft document has been prepared by Nisha Dogra and Simon Budd in consultation with Peter Yeates. This document presents a starting point as to date whilst there is much written on desirable skills, attitudes and practice of excellent clinical teachers, there is little clarity about what standards can be expected of clinical teachers (Yeates et al, 2008). Paragraphs 15-19 of Good Medical Practice (2006) which relate to teaching indicate that doctors need to develop the skills of a competent teacher but do not elaborate further. The doctor as teacher (1999) booklet outlines responsibilities but not much more. We anticipate that this document is a starting point and that as more evidence becomes available it can be accordingly adapted.

We have deliberately kept the document short to ensure it is practical and easy to implement. It is a prerequisite that any doctor who is responsible for teaching medical students is not subject to any reviews or processes that relate to their clinical practice and/or professional conduct. For this reason we have not included clinical competency and professional standards in these standards as they apply only to clinical teaching. This document is a baseline for all clinical teachers and we expect that those with other responsibilities will need to meet other expectations. Some of these statements have been extracted from Yeates et al (2008).

Standards for clinical teachers

Preparing to teach

- Has made efforts to find out the expected learning outcomes of the clinical placement
- Has reviewed student and staff handbooks where these are available

Delivery of teaching

- Encourages curiosity and independent thinking about clinical medicine
- Is able to explain key concepts appropriate to student level
- Relates the clinical teaching to previous theoretical learning
- Provides student feedback where appropriate

Teacher conduct

- Actively engages students in learning
- Demonstrates commitment to teaching by adequate preparation and making time for students

Supporting activities

- Within the parameters of the role is available to provide students with support and assistance

- Identifies and addresses any concerns regarding students they are responsible for

- Encourages feedback on their teaching

Training in clinical teaching

All clinical teachers should have attended a minimum of a two day teaching course (lots of these about and quality variable – may be easier now with schools at Postgrad levels to look at standards of these)

To attend at least a half day relevant refresher course on clinical teaching every three years e.g. clinical teaching skills, giving student feedback, learning styles.

Acknowledging and developing skills

Teaching activity in appraisal should be judged as satisfactory based on:

- Student feedback
- Evidence that they have contributed to the teaching from those organising the programme
- Observation of teaching by someone qualified to observe at least once every five years (ties up with validation).

Action needed:
There needs to be a review of accredited short courses as the quality is variable and may not equip clinical staff to undertake their role of clinical teaching.
A need to develop quality short courses that are specifically for clinical teachers

References:
GMC (2003) Good medical practice. London: GMC
GMC (1999) The doctor as teacher. London: GMC
Yeates P, Stewart J & Barton R (2008) What can we expect of clinical teachers? Establishing consensus on applicable skills, attitudes and practice. Medical education, 42: 134-142.

15 Appendix five: Learning and teaching undergraduate psychiatry (conference programme)

1.00-1.30 Registration

1.30-1.40 Welcome and setting the scene -Session chair Dr Nisha Dogra

Introduction to strands of the Scoping Group work (Nisha Dogra)

1.40 -2.40 The work of the Scoping Group

Core curriculum Stephen Cooper (Belfast)
Integrated curriculum Teif Davies (Kings)
Student attitudes Simon Budd (Leeds)

2.40-3.00 Scottish Division Undergraduate Student Teaching And Recruitment Group (S-DUSTARG): the first 5 years **– John Eagles**

3.00- 3.20 Break

3.20-4.20 Presentations – chair Brian Lunn

What makes for a good clinical experience – student perspectives Melanie Hobbs & Jennifer Howes (Leicester)
Attracting the best medical students to psychiatry Tom Brown (Scotland)
Other work undertaken by the Scoping Group Nisha Dogra

4.20-4.30 Prepare for workshops

4.30 – 6.00 Workshops

Choice of one of six:

1. How to improve teaching skills in SHOs David Dayson & Faith Hill (Soton)

2. Case based computer assisted learning modules Elizabeth Hare (Edinburgh)

3. A practical insight into expert-led PBL Jon Wilson & Xavier Coll (UEA)

4. The use of simulated patients in psychiatry teaching and clinical examination Heather Dipple (Leicester)

5. Giving feedback to failing students Richard Day (Dundee)

6. Using cinema to teach psychiatry to undergraduates – Ross Overshott (Manchester)

Day 2 November 6th 2008

9.00-10.45 Parallel sessions 1 & 2

Session 1: Promoting psychiatry to medical students – Steve Cooper

1. A survey of films and literature to identify those, which depict mental illness accurately Shomari Zack-Williams (Keele)

2. Psychological Medicine: Inspiring Medical Students Rachel Upthegrove (Birmingham)

3. Career views of FY doctors Prem Shah (Scotland)

4. Medical students' views about an undergraduate curriculum Clare Oakley (Birmingham)

5. Use of role play in mental health teaching Carlos Hoyes (Soton)

Session 2: Curriculum design –Barry Wright

1. Problems with problem based learning in psychiatry – any solutions Norbert Skokauskas (Trinity College Dublin)

2. A PBL approach for undergraduate child and adolescent psychiatry Moli Paul (Warwick)

3. A deliberately different approach to learning and teaching undergraduate psychiatry (starting from scratch) Xavier Coll and Jon Shaw (UEA)

4. Assessing and improving professionalism in medical students Koravangattu Valsraj, J Ibson & Ania Korszun (Barts and St George's)

5. Medical student perceptions of Medical Professionalism Feena Sebastian (Soton)

10.45-11.00 Break

11.00-12.45 Parallel sessions 3 & 4

Session 3: Supporting clinical teachers – Teifion Davies

1. The views of clinical teachers Nisha Dogra, Roger Bloor, Shamama Mir, Ravi Belgamwar & Subodh Dave (Leicester, Derby and Keele)

2. What makes undergraduate teaching inspirational and how can trainees be involved? Sam Baker & Kathryn Carey-Jones (Soton)

3. Getting started with e-learning: a festival of 5 lessons and screenshots Paul Hopper & Nik Martin (Soton)

4. Interprofessional education in mental health Daniel Kinnair (Leicester)

5. VISIOn (Virtual interviews for Students Interacting Online) – Evaluation of a novel teaching tool for communication skills in an external university Brian Fitzmaurice & Cathy Rogers (Trinity College, Dublin)

Session 4: Curriculum delivery – Subodh Dave

1. Seeing ECT – made easy Stuart Morris & Simon Budd (Leeds)

2. Psychiatric interviewing for diagnosis 'face to face' Lisetta Lovett (Keele)

3. Face to face post OSCE feedback to medical students Martin Humphreys (Birmingham)

4. Use of simulated patients in acute inpatient setting Paul Courtenay (Soton)

5. The use of multimedia to enhance learning Erin Turner (Birmingham)

12.45-1.45 Lunch

Session chair: Simon Budd
1.45-2.30 Improving medical educational research – Trudie Roberts

2.30-2.45 Undertaking medical education research – Nisha Dogra and Suzanne Hardy

2.45-3.15 Workshop for all delegates with set tasks

3.15-3.30 Break

3.30-4.00 Presentation of prize, where we go from here and closure

Posters:

1. Undergraduate fellowship scheme in psychiatry Julia Sinclair (Soton)

2. Use of role play in teaching medical schools Mahmood Khan (Leeds)

3. Where are UK psychiatrists made? Sheraz Ahmad (Imperial College)

4. A quantative survey of GP attitudes towards psychiatry and the undergraduate teaching of psychiatry Catherine Thompson (Keele)

5. Psychiatric Pre-speciality Training in the United Kingdom and Japan: a comparison of methods from the viewpoint of a trainee. Amy Manley (student at KCL currently FY)

6. Setting standards for clinical teachers Nisha Dogra, Peter Yeates & Simon Budd (Leicester, Manchester and Leeds)

7. The medical model in psychiatry Prem Shah (Scotland)