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Teaching psychiatry in general practice

Clinical psychiatry in Australia has predominantly been taught to undergraduates through hospital based attachments. In response to rapid increases in medical student numbers at the University of Western Australia, the School of Primary, Aboriginal and Rural Health Care began a collaboration with an outer urban hospital to integrate community general practice based psychiatry with a hospital based clinical attachment and to improve educational capacity at the hospital.

The World Psychiatric Association has called for undergraduate teaching in psychiatry to be directed toward common mental health problems. As the majority of common mental health problems are managed entirely in primary care,[1] learning psychiatry in this setting offers a broader perspective and experience for medical students. Anxiety and depression are the most common psychiatric conditions, and 78% of people with affective disorders in Australia seek care either solely from a general practitioner or from a GP in addition to other health care providers.[2]

Medical students are finding it increasingly difficult to gain adequate exposure to clinical material. Reduced length of stay and 'hospital in the home' programs, the rise in average age of inpatients, increasing severity and acuity of disease of inpatients, day surgery, and the privatisation of outpatients are significantly reducing students' exposure to and increasing competition for scarce 'clinical material' in hospitals around Australia.[3,4] This is also true for students accessing mental health problems in 'traditional' hospital psychiatric units.

General practitioners find teaching medical students intrinsically rewarding, and patients enjoy contact with students in general practice.[5] In the setting of workforce shortages and high patient demand, however, medical student teaching in general practice can impose significant time pressures on GPs and can also be costly and inefficient.

The presentation of psychiatric conditions occurs in only 1.9 patients per 100 general practice visits.[6] Many ambulatory care centres internationally have challenged traditional observer based teaching and have developed active learning models that integrate students into the primary health care team.[7] Involving the medical student as an active team member in patient care improves multidisciplinary training and practical skills training. There are good educational and adult learning principles that show improved teaching and enhanced learning when the learner has greater active involvement, clinical responsibility and timely feedback.[8,9]

Table 1. Learning objectives and problem based learning content for psychiatry clinical attachment

Key learning objectives for fourth year psychiatry term
• History taking and examination in the setting of common psychiatric conditions
• Clinical reasoning and problem solving
• Knowledge of the use and interpretation of diagnostic tests
• Psychiatric formulation
• Communication
Common psychiatric disease states featured in problem based learning modules
• Mood disorders
• Schizophrenia
• Anxiety disorders
• Organic mental disorder
• Somatisation
• Substance abuse
• Personality disorder

Integrated teaching of psychosocial factors in psychiatry and general practice has been part of the undergraduate curriculum at the University of Western Australia (UWA) since 2000. Previously however, teaching of clinical psychiatry in the fourth year of a 6 year curriculum was not integrated, and the author could find no evidence of similar integration in Australia. In the United Kingdom, evaluation of models of community teaching in clinical psychiatry has shown appropriate learning outcomes and student and teacher satisfaction.[10,11] These successful models in the UK rely on specific funding for sequestered teaching and research time for the GP. In the current fee-for-service system in Australian general practice this is inappropriate and infeasible.

Community psychiatry clinical attachment

The UWA piloted an integrated community teaching model in an outer urban regional hospital. The traditional clinical attachment in the fourth year of the 6 year psychiatry course consists of four 8 week rotations (*Table 1*). This integrated model was shared between the department of psychiatry at the hospital and general practices in the local outer urban region.

The psychiatrists provided the formal teaching for the problem based learning (PBL) tutorials, weekly tutorials for the students and ward supervision. The students also met fortnightly with the general practice coordinator to ensure continuity and resolution of issues regarding timetabling or patient contact.

Students spent half of their clinical attachments in traditional ward work and patient clerking with supervising consultant psychiatrists and registrars, and the other half in general practice with direct supervision by GPs, focusing on psychiatric history and management. Students were exposed to patients from acute presentation in primary and community settings through to tertiary and secondary care, and follow up management and care in the community.

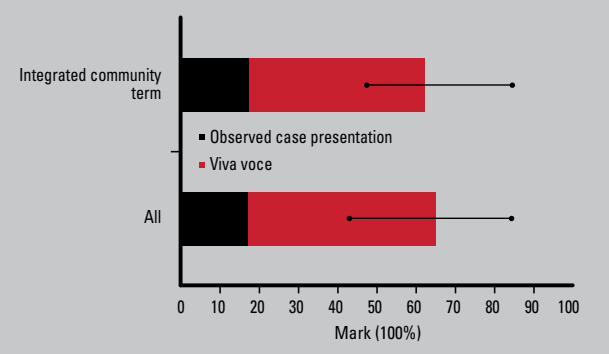
General practice teaching

The GPs compiled a 'bank' of 10–12 patients who had appropriate clinical psychiatric conditions relevant to the learning objectives. Each of these patients was asked to provide consent for the student interview. Students visited the patients either in their homes or in a spare consultation room at the practice. Students would spend a session interviewing the patient, relatives and other health providers and would then complete a full written mental health assessment with formulation and management plan for presentation to the GP. The GP, who was familiar with the patient, would be identified as the mentor with whom students could discuss the specific case. This was self directed learning with specific learning objectives.

Evaluation

Evaluation of the integrated community psychiatry term was conducted by focus group interviews with the participants (students and GPs), a comparison of final marks of the standard examination, and review of the standardised and local evaluation questionnaires.

Figure 1. Overall psychiatry mark average, 2007



Assessment and learning outcomes

The students participated in clinical cases which were observed and assessed by supervisors. These observed clinical cases comprised 25% of the students' marks for the term. The final assessment was a 2 hour viva voce in which all students participated, and comprised 75% of their marks. There was no statistical difference between the students' marks in the 'traditional' clinical attachments and the integrated and community psychiatry term (*Figure 1*).

Student evaluation by questionnaire

All students completing their psychiatry attachment were asked to complete evaluation forms. Sixty-three of 216 (29%) students completed the standard UWA formative evaluation of teaching or student perceptions of teaching (SPOT) survey. These surveys made it possible to compare the different sites of traditional teaching (54 of 63, 86%) with the integrated community teaching attachment (9 of 63, 14%) (*Figure 2*).

Each integrated student was provided with a separate optional questionnaire in which they were asked to rate the quality of the teaching in relation to each of the teaching groups on a five point Lickert scale (1=poor, 5=excellent). Thirty-eight of 39 (97%) completed the survey (*Figure 3*).

Evaluation focus groups

Students

Student interviews and focus groups revealed that the rotation provided an abundance of clinical material for students both in the hospital and general practice rotations.

This clinical material was easily accessible and appropriate to the students' level and learning objectives. This required specific and targeted administrative organisation and planning at the individual practices, facilitated by the UWA Discipline of General Practice. The clinical material in general practice was effective particularly for practicing formal psychiatric history taking and mental state examination. Students rated clinical supervision and teaching as excellent:

> 'This is the best clinical term I have done. It is well organised and the GPs know so much it is frightening. I really enjoyed it!' (Student)

Figure 2. Independent psychiatry SPOT survey 2007 (n=63/216)

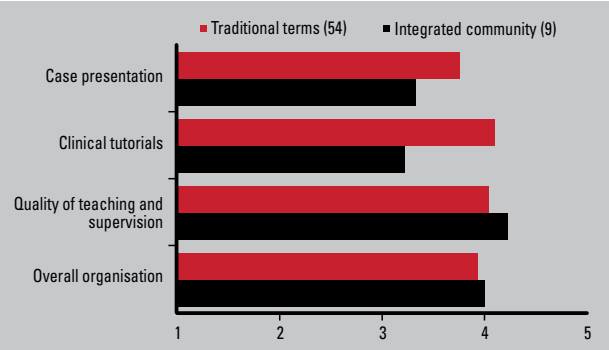
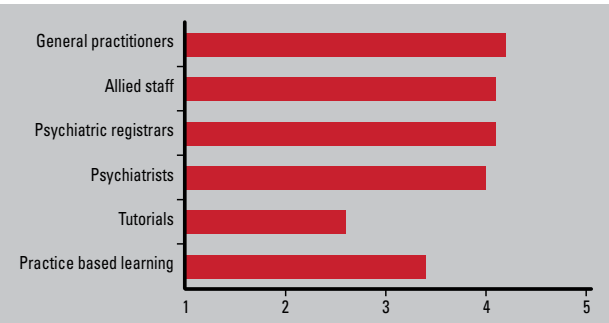


Figure 3. Integrated community term satisfaction (n=38/39)



General practitioners

All GPs reported enjoying the experience and found the teaching model efficient and rewarding. Some GPs commented that it was difficult to maintain a 'bank' of patients from all the common psychiatric disease states listed in the curriculum. They did report that the teaching model afforded improvements in efficiencies of teaching and that the students had less impact on the number of patients seen by the GP than in traditional models of general practice teaching.

> 'This was a lot more fun than I thought it would be. I really learn a lot from the medical students and the patients have enjoyed the opportunity to talk to the young doctors rather than just talking to me.' (GP)

Discussion

Experience from rural clinical schools and similar community based teaching models has demonstrated that these learning objectives and clinical themes can be met in community general practice as appropriately as in a traditional hospital setting.[12,13] This project has demonstrated similar outcomes with an integrated term of psychiatry in an outer urban setting.

This project provided increased teaching capacity in the regional hospital with the addition of community based general practice clinical teachers. The department of psychiatry at the hospital believed that they would not have been able to teach half as many students without the community involvement.

The students in the integrated term performed at the same standard as their peers at the standard examinations given by psychiatrists at independent sites. The number of students taught at the outer urban regional hospital has reduced strain on the traditional clinical attachments throughout the inner metropolitan area.

This project has also made it possible to pilot innovative models of teaching which endeavour to decrease the economic burden on practices and to improve the efficiency of general practice teaching. The training module 'Efficient teaching' developed at the UWA during this time has helped GPs to adopt economically efficient and educationally vigorous practices.

This project also made it possible to increase educational capacity in psychiatric teaching by involving general practice.

These results may have implications for training in other specialties in general practice.

Conflict of interest: none declared.

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References

1. Goldberg D, Huxley P. Common mental disorders: a biosocial model. London: Routledge 1992.
2. Blashki G, Hickie IB, Davenport TA. Providing psychological treatments in general practice: how will it work? Med J Aust 2003;179:23–5.
3. Crotty BJ. More students and less patients: the squeeze on medical teaching resources. Med J Aust 2005;183:444–5.
4. Olson LG, Hill SR, Newby DC. Barriers to student access to patients in a group of teaching hospitals. Med J Aust 2005;183:461–3.
5. DeWitt DE. Incorporating medical students into your practice. Aust Fam Physician 2006;35:24–6.
6. Britt H, Miller G, Charles J, et al. General practice activity in Australia 2004–05. AIHW cat. no. GEP 18. Canberra: Australian Institute of Health and Welfare, 2005.
7. Benson J. Impact on patients of expanded, general practice based, student teaching: observational and qualitative study. BMJ 2005;331:89.
8. Lake FR, Ryan G. Teaching on the run tips 2: educational guides for teaching in a clinical setting. Med J Aust 2004;180:527–8.
9. Vickery AW, Lake FR. Teaching on the run tips 10: giving feedback Med J Aust 2005;183:267.
10. Walters K, Raven P, Rosenthal J, Russell J, Humphrey C, Buszewicz M. Teaching undergraduate psychiatry in primary care: the impact on student learning and attitudes Med Educ 2007;41:100–8.
11. Walters K, Buszewicz M, Raven P. An integrated model for teaching psychiatry in the community. Acad Med 2001;76:563–4.
12. Worley P, Strasser R, Prideaux D. Can medical students learn specialist disciplines based in rural practice: lessons from students' self reported experience and competence. Rural Remote Health 2004;4:338.
13. Bryant P, Hartley S, Coppola W, Berlin A, Modell M, Murray E. Clinical exposure during clinical method attachments in general practice. Med Educ 2003;37:790–3.

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