The new undergraduate curriculum: implementing the changes in Nottingham

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Substantial changes are taking place to undergraduate psychiatric curricula, in response to recent General Medical Council recommendations. The overall aim is to provide a training in core knowledge and skills that enables students to become competent junior house officers. These developments will inevitably affect clinicians' involvement in undergraduate teaching. How change is being implemented in Nottingham – and the success and challenges so far – is discussed.

Readers of the *Psychiatric Bulletin* will be aware of upheavals in undergraduate education which will ultimately affect all medical schools and their teaching hospitals (Sensky, 1994). *Tomorrow's Doctors*, a review of undergraduate medical education undertaken by the General Medical Council (GMC), recommends a reduction in the burden of factual knowledge imposed on students and increased emphasis on acquiring the skills necessary for successful completion of the pre-registration year (General Medical Council, 1993). This 'core curriculum' can then be complemented by 'special study modules' – allowing students, as part of their longer-term professional development, to study areas of particular interest in greater detail. Allied to this is the need to alter teaching and assessment methods, with particular emphasis on self-directed learning. The GMC also favours the development of more integrated courses, eroding the traditional divide between pre-clinical and clinical years. Recognising the work these changes will generate, the GMC has encouraged the sharing of information on their implementation.

Existing undergraduate psychiatry teaching in Nottingham

Nottingham University Medical School is barely 25 years old. Since its founding, it has emphasised the integration of basic and clinical sciences teaching, placing the school in a more advantageous position than most to implement GMC recommendations. The bulk of existing undergraduate training in psychiatry takes place during an eight week clinical attachment in the fourth year, ending in clinical, written and presentation-based assessments. During this time, eleven days are given to lecture-based teaching. In addition, horizontal integration of teaching includes two lecture-based courses, 'Psychological Aspects of Medicine & Surgery', occurring in third and final years. Questions on psychiatric topics are included in the final MB BS written examination. There are psychiatric contributions to student teaching in obstetrics & gynaecology and public health medicine. The restructuring of the course sought to enhance cross-discipline links, but will also reduce the duration of the clinical attachment by 20% and didactic teaching by 50%.

The changes

The first task was to set out learning objectives for an identified core curriculum in psychiatry. This was begun by asking existing teachers to identify specific objectives for their lectures. Keeping in mind the needs of the house year, emphasis has been placed on acquiring knowledge and skills to deal with common psychiatric problems arising in the general hospital setting (e.g. assessment of suicide risk, management of alcohol withdrawal states). There was also a need to improve the quality of students' clinical experiences by setting out required objectives to be completed by the end of their attachment. In line with changes throughout the medical school, this has resulted in a student logbook, which allows clinical teachers to

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monitor and evaluate the student's progress through the attachment. Establishment of the core curriculum is being augmented by 'optional placements' – a range of one-week attachments within both psychiatric subspecialities and other disciplines (e.g. general practice) – where there are close links with psychiatry. Students will make their own choices, allowing them to explore one aspect of psychiatry in greater depth.

With a massive reduction in didactic teaching time, alternative teaching styles have been implemented. A handbook, produced within the department, which had served well, has been seen as discouraging students from seeking out information for themselves – it had become a mini-textbook. It is being replaced by worksheets where students will complete tasks which relate to their experiences during clinical attachments. Worksheet tasks will also help students prepare for workshop-based learning sessions, in which they play an active role. One half-day a week is being freed for students to complete self-directed learning, based on worksheets. This is facilitated by computer-assisted learning packages (e.g. in the form of multiple-choice questions) where students can test their knowledge and get feedback on progress. Workshops and tutorials will partly, though not entirely, replace didactic lectures.

The new curriculum will also result in a greater number of students passing through psychiatry at any one time. This, and the need for assessments to reflect the objective-led curriculum, required a review of existing examination procedures. The traditional clinical examination, which includes an hour-long patient interview, will give way to an Objective Structured Clinical Examination (OSCE). The OSCE includes 10 minute stations through which students rotate. Within each station, a specific task – such as the eliciting of mental state signs from video or explaining side-effects of medication to an anxious (actor) patient – is completed. Tasks are closely linked to learning objectives.

From the start, we have recognised the importance of evaluating change. Students complete detailed feedback forms and each new procedure is piloted with teachers and undergraduates. In the longer term, it may be possible to evaluate the success (or otherwise) of changes using outcome measures such as exam results or junior doctor recruitment into psychiatry.

The problems

The increased student numbers mean that we must find new clinical placements or put extra demands on already hard-pressed clinical teams. This is compensated for by an overall reduction in duration of placements, allowing firms longer periods between students. Other difficulties are less easily foreseen. Changes in service provision carry on regardless. Nottingham takes pride in being the first major metropolitan area to completely shut down its last Victorian mental hospital, but one knock-on effect is the need to alter exam formats sooner than planned because patients are no longer 'accessible' to the exam centre. High-minded statements by the GMC about interdisciplinary collaboration are not always reflected in the nitty-gritty of tough discussions on allocating shrunken teaching times to different disciplines!

The future

There will now be a dramatic shift of emphasis in undergraduate learning, away from the old apprenticeship model. This can only succeed if expectations and objectives are altered accordingly. Medical student teaching can no longer be seen as a 'watered down' version of postgraduate education. Most students do not become psychiatrists, and the knowledge they gain must be relevant to traditionally 'non-psychiatric' settings, such as general practice and acute medicine. An ability to recite first-rank symptoms may not be the most useful of skills in these roles, whereas competence in talking to distressed patients and their relatives, recognising psychological symptoms in physical illness, knowing what to treat and when to refer on, are essential to all future doctors. It is our belief that the lack of confidence of non-psychiatrists in dealing with these issues has added to the alienation of psychiatry within medicine. The new course will focus on these and related areas, giving the student at once a broader and more meaningful concept of psychiatry.

The GMC's focus on the house-officer year and the need for a core curriculum might be seen by some as restrictive; the proliferation of logbooks and learning objectives as distracting the student from essential clinical experience. The pressure to provide a

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high quality experience of psychiatry to increasing numbers of students, however, necessitates our examining all aspects of current practice to ensure its direct relevance to undergraduates. So far we have managed to introduce changes (including a reduction in the overall attachment) without any shortening in the time students spend with clinical teams. Protecting and enhancing direct patient contact, while widening the range of patient problems seen, remains a core principle in any further changes.

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