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POSTGRADUATE DIPLOMA IN LEARNING AND TEACHING IN HIGHER EDUCATION

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PGDipLATHE

University of Oxford

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Academic Tutor at Oxford University Department of Psychiatry

October 2014

Introduction:

I have always been interested in higher medical education and training and have undertaken various roles over the last few years of my training as a psychiatrist in Oxford and prior to that, through my work in Jordan.

Chapter I

Teaching Goals and Student Learning Objectives Essay

I have enrolled in the PGDipLATHE programme organised by Oxford University learning institute since September 2013 and have enjoyed attending the seminars since then. I have found the diploma an interesting opportunity to read and search the academic literature on education. It helped me to reflect on my skills and strengths as a clinical educator in addition to exploring potential weaknesses with a view of overcoming them and eventually improving my teaching.

Writing this portfolio was a challenge for me as I have not previously written academic literature but started to do so via the various assignments given throughout the course.

The purpose of this essay is to describe my own teaching goals in relation to the Teaching Perspective Inventory (TPI) .The Teaching Perspectives Inventory¹ measures teachers' profiles on five contrasting views of what it means "to teach." The inventory can be used in aiding self-reflection, developing statements of teaching philosophy, engendering conversations about teaching, and recognizing legitimate variations on excellence in teaching. When I try to put my teaching goals on words in an essay, I find this task somewhat difficult as I often think of myself as having many goals in teaching.

My Teaching Goals:

1. To improve the clinical communication skills of medical students and junior psychiatrists. Effective communication skills and mainly verbal ones are very vital in psychiatry and constitute an important part of the day to day practice. Psychiatrists can establish rapport with patients, elicit different symptomatology and arrive at a better formulation and diagnosis, and hence management plan if they are to communicate effectively with their patients. Written communication between psychiatrists and other agencies is in addition, very important and I can observe from experience that this field requires some development in both psychiatrists and other medical professionals.

2. To improve the ability of the medical students to think creatively and innovatively. This could come via augmenting their capability to learn whilst listening to tutors and patients i.e. active reflective learning. They may come up with interesting ideas and innovations.

3. To augment the learners' self-confidence and allow them to learn from their experience. We all learn from experience and the good clinician is the one who can reflect on their experiences and develop their practice. There is good evidence that heightening students' beliefs regarding their capabilities improves their motivation and eventually their learning experience².

4. To improve the students' motivation into their subject of work or study, and mainly intrinsic motivation so as to ensure the process of deep learning is happening. This can be achieved in different ways e.g. providing timely, consistent and useful feedback to students³.

Having considered the goals of my teaching, I will now consider how what my perspectives are in teaching. To do so, I will use the findings of the TPI, a tool that has been developed specifically for such purpose. I have really enjoyed taking the Teaching

Perspective Inventory (TPI) earlier in the academic year as it gave me some insight into my teaching perspectives. The nurturing perspective was dominant for my teaching profile. I like to think that I listen to the students and make them feel supported.

From analysing my Teaching Perspective Inventory results , I see that "Nurturing" perspectives are dominant for me. This may mean that the nurturing views are strongly held. In comparing the results with other colleagues, I found that another medical colleague who teaches public health, Professor Amanda Burls scored high as well on the nurturing perspectives. We found that both of us provide teaching in a supportive environment that cares for and protects the learners in a way that would make them cultivate the love of learning. This made me think of our teaching ways which facilitate students to learn and improve in a professionally- supported learning environment. Such an environment, that allows them to make mistakes without i. fear of failing or ii. criticism. It is good for me to reflect and see that I adopt the nurturing view in my teaching and I try to make the learners feel supported. This TPI result is consistent with my stated teaching goals 3 and 4, as above.

I notice that my back-up perspectives were "Transmission, Apprenticeship, and Developmental" ones as I scored within average on all of these roles. This ties in well and is consistent with my experience as a medical professional for several years which helps me master the subject I am teaching, as in teaching goals 2, 3 and 4.

The recessive perspective for me was the "social reform" role. Reflecting on these results, thus helped me to reflect on what my dominant and recessive perspectives are. This would make me more aware of these values and how they may be motivating other learners.

In addition, and on further reflection, I think I would focus on ways in my teaching that would eventually augment the scores on the social reform so as to induce more sustainable changes in the community. Thinking more about this, it might seem like a challenging issue which can be specifically addressed by possibly raising the awareness of learners to the values embedded in the topic they are studying e.g. the medical ethics of autonomy, beneficence, Non-maleficence, and justice. Having a better understanding of these principles would eventually lead to the development of safe doctors who are able to help society. My future way of teaching would focus on creating safe clinicians and very good psychiatrists who adopt holistic views adopting all the socio-demographic profiles of their patients and the patients' wider family and community networks. This may improve their practice as holistic psychiatrists and contribute to social reform.

Oxford University Department of Psychiatry Learning Objectives:

In this part of the report, I will draft the student learning objectives for the psychiatry placement for fifth year medical students:

1. Describe presentation, assessment and initial management of common psychiatric disorders e.g. depression, schizophrenia, bipolar disorder and substance misuse.
2. Lay the foundations for the skills and knowledge that students will need to manage common psychiatric problems after graduation.
3. Continue to develop communication skills with patients, communication with professionals, team-working, evidence-based practice, and clinical decision-making. These will need to be augmented throughout the course of their clinical studies whether under or post graduate.

4. Inspire some students to pursue a career in psychiatry or to have a special interest in psychiatry while training in another specialty.

Throughout my work as an academic tutor at Oxford University, I try and link the departmental learning objectives with my teaching objectives. This would be more evident when we discuss the psychiatry teaching plan that we devised for tutors to use with their students.

Summary of my objectives:

1. Organising special courses that help students and junior psychiatry registrars to improve their communication skills and mainly the verbal in addition to written skills.
2. Augmenting intrinsic motivation amongst students: intrinsic motivation can be augmented by using an assessment system that further encourages conceptual understanding e.g. PBL, case studies⁴.
3. We should also be aiming at motivating students to look at studying as a means to enhance personal development rather than a means to an end⁵. Some students may particularly see education as an instrumental tool to achieve a goal such as passing an exam, which is the superficial way of learning. Such an end could be seen in doctors who went to medical schools just to please their families or may be to earn a well-paid job. We should be aiming at creating doctors who are aiming at excellence and competence in their fields not just being 'good'.
4. Encouraging students to pursue a career in psychiatry: This will likely occur when tutors succeed in encouraging the intrinsic motivation of medical students and junior doctors. This will include timely, consistent, and useful feedback⁶. This can

also be accomplished by encouraging better perception of the psychiatry training programme by students and graduates.

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Chapter II

Michaelmas Term Investigation of Student Learning Surveys from Group 1:

Introduction:

Transformative Learning Theory was first developed by Dr Jack Mezirow in 1978 and it described the learning process of becoming critically aware of one's own tacit assumptions and expectations and those of others and assessing their relevance for making an interpretation¹. According to Mezirow, we must learn our own interpretations, rather than acting on the purposes, beliefs, judgments, and feelings of others. Transformative learning happens when learners struggle to solve problems or question the ways of doing things and are called to critically examine the premises of their perception.

E.W. Taylor² argued that transformations often follow some variation of the following phases of meaning becoming clarified:

- A disorienting dilemma
- A self examination with feelings of guilt or shame
- A critical assessment of epistemic, sociocultural, or psychic assumptions
- Recognition that one's discontent and the process of transformation are shared and that others have negotiated a similar change
- Exploration of options for new roles, relationships, and actions
- Planning a course of action
- Acquisition of knowledge and skills for implementing one's plan
- Provision trying of new roles
- Building of competence and self-confidence in new roles and relationships

- A reintegration into one's life on the basis of conditions dictated by one's perspective

I tried to see whether the learning occurred in a transformative way and followed the above ten phases.

Aim:

Transformative learning theory was chosen by our tutorial group (Professor Amanda Burls and Dr Kerry Lock) as our students cohorts from different backgrounds (medical, nursing and ecologists) used reflection as part of their practice. One of the aims of this project was to design an interview protocol questionnaire with a view of checking if the transformative learning process occurred in fifth year medical students at Oxford following their 8 week psychiatry placement i.e. if they learnt in a transformative way which is one form of adult learning. Psychiatry is so different from other branches of medicine, in that it is majorly seen as a "crisis event". It is known that many professionals including medical students have some negative attitudes towards psychiatry as a specialty in general and towards people with mental health conditions³. Improving the attitude towards psychiatry is something I would like to achieve via my teaching. Helping students to undergo the transformative learning process might result in improving such attitudes in the short term but will hopefully promote the habits of life-long learning in the future and create reflective clinicians⁴. In addition, I found that I like the concept of transformative learning as it ties in well with my dominant "nurturing" teaching perspective that was clarified in previous assignments.

Methodology:

I met with my tutorial group peers a few times to discuss and devise the interview protocol questionnaires to encompass Mezirow's phases of transformative learning. We shared the draft questions with our tutor who provided feedback on them to accommodate the main phases of Mezirow's theory. We produced an interview protocol leaflet for students (Appendix 3), explaining the purposes of the interview and thanking them for taking part (figure). We agreed to interview 5 students, each, and to share our interviews for feedback afterwards. I conducted and recorded five interviews with fifth year medical students at Oxford University who had finished their eight week psychiatry placements. Their placements involved attending clinical and academic tutorials with the specialist registrars as well as shadowing the consultant psychiatrists during their ward rounds and reviews, in addition to assessing patients on their own or shadowing other doctors.

Results and Discussion:

Please refer to Appendix 1 and 2 for the details of the interviews..

Results:

I present a brief summary of the results organised according to the questions in the interview protocol.

Q.1 Is there any way in which what you learned changed the way you do your job?

In response to whether their learning had resulted in a change on how they do their job (Interview question1) most students agreed that it had. This was reflected in their answers:

"It changed how I act in general, it helped me understand how people live"

"Yes, what I learnt in psychiatry has changed the way I perceive how I see people e.g. in Cowley Road where I live. I am more aware of the background now"

Q.2 Can you give me some examples? (prompt if necessary)

"Now, if I see a depressed patient, always ask about the evolutionary history"

"More comprehensive risk assessment of patients coming to the door, mainly risks of suicide, and harm to others"

Q.3 What was it about the course that helped you realise X or change Y "Aha moment"?

"enjoying my time in conversation with patients ,and that's a real revelation"

"I Realised how psychiatric illness is quite common, specially suicide and self harm"

Q4. How would you describe your learning experience on this course [programme/ rotation]?

"Acquisition of knowledge and skills happened. The time I spent with patients had helped me a lot"

Good, yes good. I liked the clinical and the theoretical structure of exams unlike other specialities.

Q.5 What do you understand by *reflective practice* and how do you use it for your own learning?

"Yes, I go home and think about patients I've seen, some stories affected me"

"Taking time thinking about why I did things and how I feel about that"

From the above, we can see that most interviewed medical students learnt psychiatry in a transformative way,

Discussion:

Some students came to psychiatry not knowing how to interview psychiatric patients and others had different impressions about some disorders e.g. somatoform disorders (disorientating dilemmas). They started to critique their own assumptions and question the validity of their pre-existing beliefs about psychiatry and psychiatric patients.

"What I learnt in psychiatry has changed the way I perceive how I see people e.g. in Cowley Road where I live. I am more aware of the background now".

Students learnt some valuable communication and other clinical skills that they think "are transferrable" to other specialities as they use them in dealing with patients in other specialities like emergency and obstetrics departments. Some students went to say that "they will be disappointed if I lose these skills".

There is evidence that case studies and simulations are classroom techniques associated with transformative learning (Parker, 2010) . In our placements, students were able to watch video simulations of clinical cases as well as present and discuss a variety of clinical scenarios from real life, in addition to interacting with real patients on the wards and clinics.

Examples of transformative learning were variable and included examples like conducting a good risk assessment, interviewing psychiatric patients which was challenging for some students and took them out of their 'comfort zone'.

It is relatively safe to say that students might start their psychiatry placements being in a state of 'disorientating dilemmas'. These bright students will often question their

pre-existing beliefs and concepts about a particular subject. Translating that to psychiatry, some medical students might presume that all psychiatric patients are homeless, aggressive or violent. Many of them are experiencing psychiatry and dealing with patients for the first time in their lives. With the course progression, they will "critique their assumptions" and ask themselves whether their pre-existing thoughts were valid or not. Here it comes, the "Ah-ha" moment or "lights-on experience" , as one can see in this student's reply:

"Hearing people stories is very powerful either in the context of being on the wards e.g. Littlemore , or by conversation with an acutely psychotic patient. I found myself enjoying my time in conversation and that's a real revelation".

The students went on to reflect on their experiences in psychiatry to reach certain conclusions:

"I go home and think about what I saw and learnt. I realise that a particular patient could be a member of my family or a friend"

"I learnt to look at peoples' problems more holistically as there will be a story or more than one behind each patient we meet"

These interviews have given us some insight that many students have been exploring the options for new roles and relationships as reflected in their clinical behaviour with colleagues and patients in the same rotation and the subsequent rotations (as with interviewee no.2).

Cranton⁵ defined critical reflection as "the means by which we work through beliefs and assumptions, assessing their validity in the light of new experiences or knowledge, considering their sources, and examining underlying premises" The literature highlights the central importance of cultivating a process of critical reflection with certain key elements . It is clear from the sample studied that students understood 'reflective

practice' and the majority of them used it for their learning in different ways , some of these experiences occurred by simply taking a step back , thinking and reflecting on what the student had done and how they can do better next time. Some students used it in a quite an informal 'or unconscious' way. Some researches like Cranton suggested that the most promising transformative learning potential is long term work with others and Imel⁶ concurred with the significance of establishing a community amongst learners. We can see a pattern of good working relationships with members of the mental health team in three of these interviews (60%) and examples of the expressions used were '*you were very much welcome to the team*'.

Conclusions and Discussion:

Although the sample I studied was small, I interviewed five patients in preparation for the MTI whereas other PGDipLATHE colleagues interviewed three each. From the results, we can see good evidence of transformative learning happening in medical students undertaking their psychiatry placements at Oxford.

It is evident that some students went through some (but not all) phases of Mezirow's transformative theory. At this point and on further reflection, I would critique some aspects of my interviewing process which was done in December 2013. Probably, I should have gone into more depth with each of the students about the phases of Mezirow's theory. This is a good point for the future.

Reflection on Michaelmas Term Investigation:

In this assignment, I reflect on my experience with Michaelmas Term Investigation. Honestly, I have been reflecting on my experience with MTI over the last few months and since we started preparing for the interviews in October 2013.

I was working with a group of two participants in preparing for the Michaelmas Term Investigation over the last few months and we had a few meetings (face to face and via Skype) to draft the interview protocol questionnaires, leaflets and how to conduct the interviews) and we even divided the task of writing the report amongst us. In addition, we had a meeting with our course tutor nearly a week before the deadline for submission of the assignment and sharing it with the other group. Initially, I had difficulty in recruiting students, as many of them were undertaking their final exams around November-December 2013. At the end I managed to interview 5 students and they were all happy to take part and were happy for us to publish the interviews if required.

Because of the fact that I grew up and learned and qualified as a doctor in a different country with a different educational system and background, it was interesting to see the differences in students' experiences here in Oxford. Our undergraduate medical education in Iraq was to some extent relying on spoon-feeding the learner rather than encouraging them to explore deeper ways of learning. We didn't have the opportunity to give that much 'if any' feedback to our tutors (especially in the pre-clinical years) and their teaching methods. I was positively struck by the educational system in Britain whereby learners could easily give feedback about different aspects of their teaching like the way of teaching, tutors' attitudes and styles...etc.

When we (other group participants and I) were discussing the results of the interviews, we found some interesting findings as my learners were in a state of 'disorientating dilemma' prior to starting the course. Some of them were under the impression that all psychiatric patients were homeless 'mad' people and these students were questioning themselves about the difficulty of interviewing such patients. With time and throughout the placement, these students found out that many of their psychiatric patients had families and real life stories behind each of them. Some of the students found that these

patients were victims of some kind of emotional, physical, or sexual abuse which largely contributed to their psychologically development and personality make-up. This clarifies how the dilemma was questioned with the progression of the course and clinical practice, and they were all able to take up new roles in comparison with other learners that my colleague, Professor Burls interviewed (in the domain of public health) and tried to create that state of 'dilemma' by making the learners question their existing assumptions of the concept in question.

Interviewing my students was really good and useful and I learnt that most of the students interviewed used reflective practice and think about what they have done and how can they improve in the future. This is for me, reassuring as reflective thinking would create safe and committed clinicians. It was also heartening to see how some students liked the way they were taught at the psychiatry placement and wanted to be more involved in related activities e.g. visiting the psychiatric intensive care and prisons. They thought they were supported by the consultant psychiatrist and the clinical team till they became more independent and confident in dealing with patients. This is a nice example of cognitive apprenticeship whereby the educator trains and educates the learner via 'scaffolding'. I would like to think that I provide the students with a safe and supportive environment for them to learn and I encourage them to follow and abide by the General Medical Council good practice guidelines. The feedback I am and have been getting at the end of their placement has always been good and there were some suggestions for improvement like having more structure to the tutorial.

I started to reflect about my teaching and how could I improve that. There are some ways that I am currently pursuing like reviewing education literature in addition to input from the PGDipLATHE course, meeting and discussions with colleagues and mentor e.g. I recently learnt about the 80/20 teacher talking time rule and on reflection, I think I was

at times talking more than my students did, which could have potentially inhibited their learning.

As we were approaching the deadline for submission when one of the participants suddenly pulled out (less than 48 hours prior to the deadline) of the programme due to intense work commitments. Around that time I had a mixed feeling of being 'disappointed', and 'stressed' and I discussed this with my mentor and tutor who were both very understanding and supportive. That experience in itself was a good learning one for me. I learnt how to manage my work effectively under pressure and tight deadlines. In addition, I appreciated the other colleague's commitments and wanted to compensate for her role in drafting the MTI report by putting extra work on it.

Our group presentation on 16 January 2014 generated a good debate and discussion between the audience and the presenters as the audience seemed interested in knowing more about the concept of transformative learning and appeared keen to know some practical examples.

The presentations from other groups were interesting and useful as I learnt about various concepts like phenomenography, teaching styles and attitudes. In addition, it was interesting to discuss and give feedback to the other group we were assigned to read and give feedback on their report (group 2), they have chosen the types of reflectivity and how medical student's reflected on their practices. There was an allusion in their report to Jack Mezirow 's work on transformative learning was central in their analysis of critical reflection. I also learnt about thematic analysis and how to use it in analysing and transcribing qualitative data.

Whereas some feedback forms reflected that some of the audience found the subject interesting and new to learn about, others showed that some participants found it a bit

unclear or some were still confused about it. Overall, it was a good experience to have and share the knowledge with colleagues.

When I think clearly about it now, I need to make some changes in my teaching style. For example, I need to give more time for the learners to discuss amongst themselves, an enhancing the practice of learners' feedback amongst themselves and on the teaching style and methods.

References:

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Chapter III:

Introduction of the Teaching Plan for Academic Tutors in Psychiatry:

In this chapter, I will reflect on my experience in teaching psychiatry to undergraduate medical students at Oxford medical school. The system that is in use for many years is 'tutorial-based' of which there are 2 types, academic and clinical. The academic tutorials focus on helping the students to gain the relevant knowledge and understanding of psychiatric assessments and common psychiatric disorders whereas clinical tutorials focus on the useful clinical and communication skills those learners would ideally gain during their psychiatry placements of 8 weeks.

I worked as a clinical tutor for a few years and have taken up the role of an academic tutor since January 2014. My current group of students comprises of 5-6 students and usually last for 75 minutes. Although they are called tutorials, I usually envisage them as examples of a 'small group teaching'.

When I first met with my supporting PGDipLATHE mentor, Dr Denis O'leary, we discussed my ways of teaching medical students and we agreed that I was delivering that on a random rather than a planned basis and that was clearly reflected in previous feedback forms from medical students. Some students mentioned that I needed to put a clear structure to my tutorials and discuss a new subject at each new tutorial, for example. Denis and I agreed to devise a teaching plan to use with the medical students (see figure below, teaching plan 1).

I started implementing this teaching plan from the beginning of my role as an academic tutor to oxford medical students in January 2014. Dr O'Leary attended the first few tutorials to get a flavour of how it was happening in real life in addition to observing my teaching style.

Below, I will explain the structure of the academic teaching plan with the different headings and sub-headings.

Tutorial Aim:

Academic tutorials are designed to help students to acquire relevant knowledge and understanding in psychiatry. This is specified in the curriculum. Inevitably, however, the role of academic tutorials will overlap with that of clinical skills tutorials. I had some questions from learners about the difference between academic and clinical tutorials and the difference is that clinical tutorials focus on the clinical and communication skills of psychiatric history taking and mental state examination.

Tutorial Format:

The tutorials will be structured and students will actively contribute to academic tutorials by reading around the subject and preparing material in advance. This will include student presentations on topics and reading around topics so as to participate in any discussions. Students are all graduates, and the tutor is therefore there to facilitate learning and discussion, rather than to provide the answers. Teaching of knowledge relating to common physical and psychological treatments should be integrated with teaching about the common conditions, rather than being delivered separately. There is insufficient time to cover all topics within the attachment. Some topics will need to be covered in students' own time or elsewhere, but after four weeks students may be asked which topics they would like to cover. Although the content of tutorials will usually relate to core knowledge as specified in the learning objectives, as in any Oxford tutorial, discussion will not be limited to this.

Ice breaker:

In group meetings for the first time it is useful to have an introductory “icebreaker”. The example chosen involves: learners will be working in pairs, asking of each other, noting the answers to three questions and then reporting the answers to the group. The question area as follows:

- What do they want to get out of the course?
- Why?
- Tell of something interesting of themselves to share with the group?

The first two are designed get the learners to reflect on their aims for the course and how they relate to their personal motivation; the third is essentially the icebreaker.

Clearly if there are an odd number of learners then the tutor may join as the other partner. If so they should be prepared to answer question three as well. From experience the learners may ask the tutor to share something interesting of themselves. In any event it is up to the tutor to decide whether to respond or not. The third question may become something of an identifier for the group. For example when a new member joins in session two the existing members may spontaneously ask that they share something interesting of themselves.

Group Processes:

This may be an appropriate point to consider some group dynamics. Tuckman¹ identified how the group may pass through four stages over the course:

- Forming
- Storming
- Norming
- Performing

The first three stages are likely to progress over the first two sessions; the fourth by the third. In **Forming**, the individual's behaviour is driven by a desire to be accepted by the others, and avoid controversy or conflict; **Storming** is where students' different ideas/learning needs compete for consideration. In the **Norming** stage group members take responsibility and have the ambition to work for the success of the group's goals. Setting out the group aims, format and processes at the initial stages should facilitate the first three stages and move to **Performing**. It is likely that Storming and Norming will emerge at discussions of what topics they wish to include at and from Tutorial four. Increased evidence of Performing should emerge after tutorial four onwards.

Discussing the Group Processes include:

- ✓ Times and duration of tutorials.

- ✓ Student attendance – the Department's guidelines say that students should prioritise attendance at academic and clinical skills tutorials. However, occasionally they will not be able to attend, and, in that case, they are expected to give their apologies in advance. The alignment of these processes and the first item of the end of attachment assessment could be noted.

- ✓ Respect for others' contributions; preparation beforehand; peer and tutor feedback; evaluation of the session.

- ✓ One to emphasise is agreeing that the tutor may challenge and encourage.

- ✓ Several of these processes are fundamental to good teamwork and the Tutor should elicit how they are transferable to clinical practice e.g. when they are consultants or GP lead etc. and contribute to good clinical care.

- ✓ A key component of effective peer interaction, learning and team work is appropriate feedback.

Models of Giving Feedback:

The Group may have discussed Feedback in their first clinical Tutorial. If so, the tutor could check the students' understanding of the process and agree it is used. A common model for giving feedback in clinical education settings that you may have come across was developed by Pendleton (1984).

A simplified version of **Pendleton's** rules is given below; note the guidance regarding action planning is often forgotten.

- Ask the Learner to identify what they did well
- Ask the Peers what the person did well
- Tutor adds their view on what was done well
- Ask the Learner to identify why they would do better next time
- Ask the Peers what the person could do better next time
- Tutor adds their views re areas for development
- Ask the Learner how they will action the identified changes.

The Tutor elicits what the learners understand the purpose of feedback to be and how is it relevant to student performance and patient care. The tutor is looking here for learner responses around self-awareness and development; team development and how patient care can be improved as a result of both. May link to revalidation and portfolio development when in Foundation years.

Ironically many medical students will offer that they do not wish to receive positive feedback – that they want to focus on the areas for development; don't mind if it

presented as a criticism as long as it is useful; have a personal problem with receiving/accepting positive feedback. The group may choose not to use the Pendleton rules – if so they can be always written on the board in the room as a reference. It is useful in this situation to point out once again that they will be team leaders and that other team members may only be able to accept effective feedback if areas of doing well are included with areas for development (the marriage guidance counsellors advise that for one to hear one negative comment a partner has first to receive five positive ones!). Explain how the method promotes reflection on the part of the individual learner and of the peers; promotes good team-working and multisource feedback. It also promotes Action Planning for the future – i.e. helps to alter behaviour/attitudes etc.

Tutor may ask the learners to describe their experiences of receiving feedback; ensure that you elicit episodes where feedback was experienced as negative and. It is likely that most will volunteer negative episodes - explore how the Learner felt at that time and how it affected their self-esteem and motivation to learn; ensure that you elicit a positive experience and what the positive elements of that experience were.

Although this model provides a useful framework, there have been some criticisms of its rigid and formulaic nature and a number of different models have been developed for giving feedback in a structured and positive way. These include reflecting observations in a chronological fashion, replaying the events that occurred during the session back to the learner. This can be helpful for short feedback sessions, but you can become bogged down in detail during long sessions. Another model is the 'feedback sandwich', which starts and ends with positive feedback.

When giving feedback to individuals or groups, an interactive approach is deemed to be most helpful. This helps to develop a dialogue between the learner and the person giving feedback and builds on the learners' own self-assessment, it is collaborative and helps learners take responsibility for their own learning.

"A structured approach ensures that both trainees and trainers know what is expected of them during the feedback sessions. Vassilas and Ho² describe a model adapted from Kurtz and colleagues³, summarising the key points for problem-based analysis in giving feedback to groups as follows.

- Start with the learner's agenda.
- Look at the outcomes that the interview is trying to achieve.
- Encourage self-assessment and self-problem solving first.
- Involve the whole group in problem solving.
- Use descriptive feedback.
- Feedback should be balanced (what worked and what could be done differently).
- Suggest alternatives.
- Rehearse suggestions through role-play.
- Be supportive.
- The interview is a valuable tool for the whole group.
- Introduce concepts, principles and research evidence as opportunities arise.
- At the end, structure and summarise what has been learnt.

Vassilas and Ho (2000) identified that medical educationalists claim that using this method for groups and individuals is more likely to motivate adults, in particular, to learn. Initially, grasping this different way of working can be more difficult for trainers than using the traditional didactic approach, but research into using this method supports its effectiveness in clinical settings. The widely used Calgary-Cambridge approach to communication skills teaching (Silverman *et al.*, 1996)⁴ is referred to by Walsh (2005) in his summary of 'agenda-led, outcomes-based analysis': 'Teachers start with the learners' agenda and ask them what problems they experienced and what help they would like. Then you look at the outcomes that they are trying to achieve. Next you

encourage them to solve the problems and then you get the trainer and eventually the whole group involved. Feedback should be descriptive rather than judgmental and should also be balanced and objective”.

Below I will present the structure of the teaching plan.

Psychiatry Tutorials - Session 1: Assessment

Aim: Describe the generic assessment of psychiatric disorders.

Intended Learning Outcomes: By the end of the session the LEARNER WILL BE ABLE TO:

1. Understand the Group Norms and process
2. Feedback: Understand rationale, and be able to give feedback appropriately
3. Describe their Learning Style
4. Agree the use of an Individual Learning Portfolio and component (Personal Development Plan and Reflective Notes)
5. Describe the key components of Assessment
6. Describe the Headings of the Psychiatric History
7. Locate the Headings of Mental State Examination.

See figure below:

Time	Activity	Learning Method	Resources	Assessment	Evaluation
5 min	Introduction to group members	Paired discussion & report			
5 min	Set Group Norms	Tutor states norms Elicit re team-working	Tutor Notes	Throughout Session Tutor to be mindful of (i) individual learner participation/contribution	Complete Evaluation Sheet Section
	Aim and ILOs	Tutor States	Handout	(ii) Identify Learners' attitudes and motivation	
10 min	Feedback	Tutor elicits rationale Group discusses experience of feedback Elicit methods			Complete Evaluation Sheet Section

<p>10 min</p>	<p>LSI: identify Learning Style</p>	<p>Give Pendleton's rules</p> <p>Tutor Introduces Honey & Mumford LSI</p> <p>Learners complete</p> <p>Discuss of application of LS</p>	<p>Handout of Theory</p> <p>Questionnaire</p>		<p>Complete Evaluation Sheet Section</p>
<p>5 min</p>	<p>Individual Learning Portfolio</p>	<p>Tutor leads</p>			

	<p>Learning Diary Reflective Notes</p> <p>Develop Personal Development Plan</p>	<p>Tutor introduces template</p> <p>Refer to Dept. Goals (LOs)</p> <p>Introduce a personal goal (LO)</p>	PDP Template		
<p>30 min</p> <p>5 min</p>	<p>Assessment History Taking</p> <p>MSE</p> <p>Physical exam Investigations Collateral History</p>	<p>Elicit Five Components</p> <p>Work in Pairs to draft the headings of a psychiatric history</p> <p>Present outcome to the Group</p>	Departmental		

		<p>Compare with Departmental template and discuss differences.</p> <p>Introduce the Mental State Examination</p>	<p>Template</p> <p>Departmental Template</p>		
5	Patient Confidentiality	<p>Tutor states appropriate practice</p> <p>GMC guidance for doctors</p>			
	Work between sessions	<p>Identify psychopathology reading</p>	<p>Departmental reading list</p>		

		Prepare questions on that chapter			
		Give out Checklist for history taking and MSE (mental state examination)			

Personal Development Plan

We introduced a template for a personal development plan (PDP) that is comprised of three columns – learning outcome/how achieved/how assessed (see figure)

Intended Learning Objectives	How Achieved	How Assessed

Signature:

Date:

Tutor's Signature:

Date:

Feedback or Evaluation Sheet:

Feedback on Tutorials:

Students were asked to fill in the evaluation forms (see Appendix 4) at the end of each tutorial. For example, the forms asked the students to rate 'how confident' they were that 'attained the Intended learning outcome' and how 'helpful was this approach compared to previous group learning experiences'. We have been getting good feedback over the subsequent weeks. Some students identified the feedback forms as a bit long and we had to tweak them a bit to make them shorter and easy to be filled in after tutorials.

Evaluation Sheet:

Headings

Helpfulness

1. Not at all Helpful
2. Slightly Helpful
3. Somewhat Helpful
4. Helpful
5. More than Helpful
6. Very Helpful

Confidence

- Not at all Confident
- Slightly Confident
- Somewhat Confident
- Confident
- More than Confident
- Very Confident

Learning Outcomes
How Confident are you that you have attained the Intended learning outcome? 1

2 3 4 5 6

Give a reason(s) for your rating

How well did the learning methods help you attain the Learning Outcomes? 1

2 3 4 5 6

Give a reason(s) for your rating

Overall Rating

Overall how helpful was the session to your learning? 1 2 3 4 5

6

Give a reason(s) for your rating

What changes would you recommend

Overall how helpful is this approach compared to previous group learning experiences

1 2 3 4 5 6

Give a reason(s) for your rating

What changes would you recommend

Overall how motivational/inspirational is this approach compared to previous group learning experiences

1 2 3 4 5 6

Give a reason(s) for your rating

What changes would you recommend

Overall how enjoyable is the approach compared to previous group learning

experiences 1 2 3 4 5 6

Give a reason(s) for your rating

What changes would you recommend?

Sign:

Date:

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Chapter IV:

Experimentation with Academic Psychiatry Tutorials at Oxford University:

Why do I see these tutorials as a good strategy of teaching? There is evidence to suggest that student satisfaction and sense of preparedness for the examination both improved with active learning¹. In the Morreale study and in two consecutive academic years, two groups of students were compared after completing a 1-month psychiatry clerkship. The first group (N=108) received traditional lectures, and the second (N=102) was taught via active learning. Participants were surveyed regarding satisfaction, sense of preparedness for an exam, and expressed likelihood of choosing psychiatry as a specialty.

There have been several studies to look at the students' attitudes towards psychiatry as a future career and psychiatry has been negatively regarded by medical students in different countries. Lyons² and in 2013 undertook a systematic review of 32 educational papers where more than 12000 students' were interviewed. They concluded that in order to encourage more students to consider psychiatry as a career, attention needs to focus more closely on the psychiatry curriculum and the development of innovative teaching strategies.

There is evidence both from pedagogical literature and real life experience with students to suggest that tutorials promote 'deep learning' as they keep both parties (facilitators and learners) stimulated and also forces better preparation of the learners in between the tutorials. I usually prepare for the topic of each tutorial according to a teaching plan and undertake some readings relevant to the content of that specific tutorial well in advance.

The tutor/facilitator has a demanding task to ensure that new ideas useful to the student are inserted intelligibly into the exchange of views (Archaeology and Anthropology-guide to good practice, Oxford learning institute). This has been evidenced in my recent experiences with the fifth year students as I allowed them to adopt a student-led approach which was very well received by them, as seen in their evaluation forms at the end of each session. They were able to engage in respectful discussions and exchange information in a professional way. They have the opportunity to seek the expert's (tutor) input if they needed to clarify a controversial point. The role of the teacher is to emancipate the students from dependence on him and other authorities as the knowledge and competence, and to encourage their own maturation³.

During these sessions, we have implemented some methods like:

- A 'buzz group' whereby students are asked in small groups of two or three to discuss an issue e.g. differential diagnosis or management for a few minutes and then information was shared to the whole group.
- Peer tutoring: this has been developed over the last several months and mainly since February 2014, and this was facilitated by the tutor. On one occasion, the students ran that effectively in the absence of a tutor as he turned up late. Students found this very helpful and I was pleased to see them coalescing into a single group, united with the aim of teaching each other's and sharing their experiences.

Hodd and colleagues (2011) looked at a psychiatry tutorial programme at the University of Western Australia (UWA) and concluded that this programme encouraged students to use more effective learning approaches by scaffolding the development of effective

problem-solving strategies, and by reducing examination anxiety. The authors concluded that “the overarching goal of the tutorial programme is to improve students’ experiences in the psychiatry module by: (i) enhancing the development of generic problem-solving skills, providing better alignment between the module content and the module assessment methods, and increasing the clarity of goals/standards within the module; (ii) fostering students’ use of the deep learning approaches identified to be essential for clinical skill development, and; (iii) reducing undue anxiety about the end-of-module examination, which interferes with higher-level learning processes”. The programme added to a growing body of evidence on methods to augment problem-based teaching practices in psychiatry education. In this study, the numbers of students in each tutorial group was not mentioned but the authors focussed on the overall teaching approach using problem-based learning practices.

My argument that tutorials provide a more robust example of enhancing deep learning practices, is that tutorials, those comprising of five-six students help students to think at deeper levels for the following reasons:

- All students will have a fair amount of contribution at the tutorial even the ‘shy’ or ‘quiet’ ones and that follows preparation in between tutorials.
- Tutorials enhance the experience of Individualised teaching and individualised feedback.
- Tutorials help in augmenting the personal development of academic skills amongst learners as they will be engaging in detailed conversations and scientific arguments, which promotes professionalization of learners).
- More timely feedback: there is more opportunity for a timely feedback in smaller groups compared to larger ones.
- More interesting and engaging, and enjoyable.

- Tutorials allow better control of the educational environment, and more space for brainstorming in addition to higher order thinking.
- Tutorials provide scope for the development of close professional academic relationships between tutors and learners. The importance of face-to-face contact in improving communication cannot be overestimated. Physical proximity is very important for human communication (Abercrombie, 1964) and this is clearly seen in small tutorial groups in comparison with larger groups, as, for instance, in lectures.
- Tutorials help learners to acquire the basic academic skills and act like professionals in their discipline.

Additionally, The presence of 'buzz groups' and peer tutoring was a uniquely interesting features of these academic tutorials and that was one of the main additional reasons of its success, as reflected in the learners' evaluation of these tutorials.

As discussed before, and given the lack of a solid structure or framework to my tutorials, I agreed with Dr Denis O'Leary to observe me during the academic tutorials I was delivering according to the new teaching plan. One of his feedback points was that following the first tutorial, one of the things that were especially good was the development of a teaching session plan that was structured and easy to follow in addition to adopting a very good personal style to engage students in the tutorials. In addition, he suggested to consider the preferred tutor: learner ratio of talking time 20:80. He observed that I was talking for more than 20% of the time and recommended that I work on drawing out student participation more. .

Following the last tutorial in the previous placement which was in early March 2014, Dr O'Leary commented that the tutorial was more along adult education lines, with the

tutor acting as facilitator and assessor rather than a more didactic approach and that followed the implementation of some approaches like tutor: learner ratio of 20:80.

It was an interesting experience for me to deliver these tutorials according to the new format, but not to forget the anxiety feelings ' of being observed by a senior colleague and an educationalist' that were present in the first few tutorials. Fortunately, this anxiety subsided with time and I was able continue enjoying my time in these tutorials. This observational style helped me to build my confidence as a fledging educationalist in the field of psychiatry and helped me to cement my feet in that career.

Psychiatry Tutors at Oxford:

At the Oxford university department of psychiatry, there around 6-7 academic tutors and a similar number of clinical tutors during each eight week psychiatry placements. Each tutor (academic or clinical) usually delivers between 5-7 tutorials during the first seven weeks of the placements and spares the last one for students' revision and exams. These tutors are core specialty registrars (during their 3 years of core psychiatry training) and specialist registrars (advanced trainees in psychiatry undertaking subspecialties e.g. forensic, child and old age psychiatry).

These tutors are usually recruited by the department of psychiatry on a voluntary basis (i.e. not salaried) from a group of registrars who are interested in medical education and training. There are formal departmental guidelines for the academic and clinical tutorials but tutors usually have the flexibility of structuring their tutorials at their pace and convenience, as long as they cover the main subjects.

Tutorials are held over a period of 75 minutes (for academic) and around 60 minutes (for clinical) tutorials. Tutors are not usually observed by another colleague during teaching but my experience of being observed occur due to the fact that I was undertaking the PGDipLATHE programme.

Administrative coordination and division of the students amongst tutors is usually effectively held by the departmental administrator, Suzanne Williams under direct supervision of Dr Jonathan price (Honorary Senior Clinical lecturer and Consultant Psychiatrist).

As with any new development taking place simultaneously in many different locations, there is a need for dialogue and sharing of good practice, so we started introducing the new method of delivering psychiatry tutorials with other academic and clinical tutors (who are specialist registrars at Oxford i.e. doctors specialising in psychiatry) and some of them have started delivering them in the new format from March 2014.

Tutors have been getting variable feedback from different groups of students e.g. one group preferred the didactic method of teaching whereas the other group (I was teaching) preferred the newer student-led method. I think it would be interesting to follow these students up and see how they will progress in their academic studies and careers e.g. how they will do at final exams and whether this method and strategy of learning was different from the previous learning methods they have used in the past. I am planning to introduce the new method of delivering psychiatry tutorials into other schools of psychiatry in the United Kingdom and have already started making contacts with some deaneries in that regard.

I am hopeful that this teaching method will ensure a smooth application of the concept of constructive alignment (Biggs , 1996)⁴ as it helps the learners to achieve their intended learning outcomes in line with the current system of students assessments via clinical examinations.

Reflections on the new tutorial model:

In this part I will be trying to think about whether the new way of delivering academic tutorials in psychiatry at Oxford (which I started and a few colleague tutors) have started will influence the students' (learners) satisfaction and sense of preparedness for the final examination in psychiatry.

The new way of delivering these tutorials and as I explained in previous assignments in this course have enabled the student to exert some kind of educational leadership as they have been able to lead some of the tutorials amongst themselves and seeking expert's input when required. This method seems to have gone well over since March 2014 and it is likely that it augmented their deep and active learning styles. Although this has not been formally assessed, but the feedback we have been getting reflected it as learners found it more enjoyable and interesting than the previous learning methods they have experienced before. In addition, some learners commented in their feedbacks that they felt more confident in assessing psychiatric patients and achieving the intended learning outcomes of gaining basic knowledge and understanding of the major conditions and principles of psychiatry. The learners agreed that they found this method motivational and inspirational compared to previous group learning experiences "useful learning experience within small group setting" and "good discussion within the group".

I haven't yet assessed the students' preparedness for clinical examinations or for their interest in psychiatry as a specialty and whether this has changed before and after having their placements but this is something worth considering in the future.

Through my work on the Michaelmas Term Investigation and the reading on the transformative learning theory and student experiences, I came to realise that we should arrange our tutorials and teaching to enhance the transformative learning

experience of medical students' and as it is a form of powerful adult education (Mezirow, 1978)⁵. The students' I interviewed agreed that the skills they learnt during their psychiatry placement were sustainable and transferrable and changed the way they looked at psychiatric patients as they adopted a 'holistic' view of assessment and management considering the socio-demographic backgrounds of patients. There is evidence to suggest that participation in a psychiatric module may be associated with a positive effect on students' knowledge about, experience with, and attitudes toward psychiatry⁶.

Recruitment into psychiatry has been seen as a relative problem in many countries due to different reasons, like the stigma associated with psychiatric patients and people who work with them. In addition, the undergraduate teaching in psychiatry seems to be an important causative factor.

Searching the literature and specifically talking about medical sciences, I have seen that researchers have frequently assessed the (students) learners' experiences about different educational aspects like their learning experiences and different teaching strategies, and relatively ignoring the teachers' experiences and how they feel when they teach and whether they get any support or mentoring from their seniors or supervisors. It was interesting to see a paper by Crisp-Han et al in the Academic Psychiatry Journal, 2013 looking at psychiatry training programmes in the USA and 'what and how residents are taught about teaching'. The authors concluded that most training programmes provided formal teaching which included evaluation and feedback, lecturing skills, small-group skills, learning theory, and problem-based learning. Instructional methods used were predominantly group discussion, lecturing, reading of relevant literature, role-playing, and audio-visual instruction. In my opinion, it is vital that we provide teachers with the adequate skills that they could utilise in teaching their learners but this can be

challenging given the changes facing clinical education in the modern NHS with the move towards a more service delivery-based model.

The UK in general and Oxford specifically have become major sites of multi-culturalism and I think it is important that we cover cross-culturalism in our training and incorporate these principles in the curricula of undergraduate in addition to postgraduate training in psychiatry. An interesting study by Lyons and Lugharne in 2006 concluded that there needs to be more attention given to teaching of cultural psychiatry in the undergraduate curriculum given the fact that students' exposure to cultural issues is inevitable as they progress through the clinical years of their training in both hospital wards and community settings. This has opened my eyes to the possibility of discussing this with the Royall College of Psychiatrists International medical Graduates to include more culturally diverse subjects into the postgraduate speciality training curriculum in psychiatry.

What I have concluded over the last few assignments, is that I started to enjoy reading and reflecting on the academic literature specially those related to my field of work in psychiatry and medical sciences.

Potential Enhancements to the Learning Environment:

In my opinion, there is a potential for strengthening the learning experiences of medical students at Oxford. Through the teaching plan I devised in collaboration with my mentor, Dr O'Leary, we recommend that the academic tutorials in psychiatry are led by undergraduate medical students so they would do short presentations and ask other questions. In addition, there will be an opportunity for them to prepare certain topics prior to each tutorial. At each tutorial, we agree that some students will prepare topics for the next tutorial , e.g. aetiology, diagnosis and treatment of schizophrenia. Each

student will ask their colleagues about that topic and this will usually generate a more or less informal but respectful atmosphere for interesting discussions. This will encourage the students to reflect about the patients they have seen, as well as improving the tutors' motivation to learn. The 'expert input' will always be there as the tutor will intervene at the right time to provide the right information, solve a clinical debate or share their experiences with the students. This method will reinforce peer-peer teaching.

Future directions:

What I would like to see in these tutorials is having a smaller number of students per tutorial group. I am aware that this option will be more resource intensive as it would require more tutors per student cohort and that seems to be the main challenge, in addition to other logistics such as room availability and administrative support.

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Chapter V:

Improving the Learning Environment:

Introduction:

Improving the learning environment in psychiatric hospitals is challenging. This is due to a variety of factors like the widespread psychiatric units and clinics across the counties and the demands of service provision at the expense of training. Teaching psychiatry to medical students and postgraduate training registrars interesting thing to do and that what I found it from my experience. We have seen from the MTI that psychiatry teaching to undergraduates involves “transformative learning” especially if is it well delivered by enthusiastic educators.

What I propose in this assignment is introducing the structured teaching plan for clinical and academic tutors to the Department of Psychiatry at Oxford University that I discussed in a previous chapter of my portfolio. There are a lot of challenges that one can face when they try to impose an educational change especially to a well-established system, Like Oxford.

In addition , I am thinking about ways whereby registrars in psychiatry are taught how to teach medical students. Psychiatry registrars can learn how to teach in different ways, like observing their supervisors and attending training courses.

One way would be that local departments increase and augment the academic activities held which can be arranged as a bi-weekly events usually over lunch. These would involve preparation from registrars and doctors in training as well as doctors from other grades. Selecting motivated registrars to deliver the teaching is an integral part of the

teaching process. In addition, encouraging junior registrars and students to think and reflect about their experiences would be a pivotal aspect in that process.

Psychiatry has always been an interestingly controversial branch of medicine and a lot has been discussed and written about with regard to the psychiatric patients, professionals and more recently, "teaching psychiatry" to medical students and postgraduate doctors.

In writing up to this assignment, I studied different educational papers of interest and reflected upon my experience of teaching, and how the learning environment can be improved.

How to Improve the Learning Environment:

There is evidence that psychiatry teachers, who adapted new teaching methods, were able to induce a significant improvement in the training process. This was reflected in a safe educational environment; having an extended period of time for assessment and further management; and more direct, rather than "diplomatic," feedback¹.

A. Use of multimedia in learning: in this expanding world of technology, advancement of technologies has stimulated the production of more interesting and effective approaches in teaching and learning context.

- **Using mobile apps for learning:**

The rapidly advancing mobile computing technologies along with abundant mobile software applications make ubiquitous mobile learning². From observations; I find that enthusiastic young students and doctors find the use of mobile apps very interesting and challenging at the same time. Higher Education Thames Valley (formerly Oxford Deanery) has recently been emphasizing the use of mobile and computer apps to

improve the learning process. I recently chaired the organising committee which organised the Oxford medical education conference in May 2014 and there was an interesting talk by a junior doctor, Asli Kalin who won the deanery's prize for 'Challenge 2023' in teaching innovation. She developed a mobile application for new junior doctors that would familiarise them with the system of the hospital and how and where they could order the appropriate investigations and tests in a timely manner.

I am planning to encourage more clinical educators to seek support from informatics specialists to design appropriate mobile apps for psychiatry. A colleague and I started to work on a mobile app that would aid the non-medical professionals to diagnose major psychiatric conditions during routine and emergency assessments. This potential app would greatly help the non-medical professionals in diagnosing the psychiatric illnesses (e.g. schizophrenia, bipolar disorder and their subtype) without the imminent need for a doctor to be present. In addition, it would be necessary to augment the clinicians' knowledge and understanding of the classification of psychiatric disorders (according to ICD 10 criteria). Generalising this experience and involving senior registrars in similar projects might have some rewarding results and outcomes. The rationale behind using such apps would possibly provide a scaffolding skeleton to enable learners (clinicians) to work in a more authentic way, whereby they learn from the experts clinicians (Collins et al, cognitive apprenticeship, 1987). Alongside clinical experience, the presence of such app might encourage the learner clinicians to examine evaluate existing ideas and possibly predict outcomes (Bloom's taxonomy).

The evidence into the use of mobile apps for learning is scarce at this point but this might not be the case in the near future as more learners might be interested in this field which might generate more evidence. An American study conducted by Hsu, Yu-Chang (2013) explored how educators with limited programming experiences learned to design mobile apps through peer support and instructor guidance. Educators

were positive about the sense of community in this online course. They also considered App Inventor a great web-based visual programming tool for developing useful and fully functioning mobile apps. They had great sense of empowerment through developing unique apps by using App Inventor. This study helped reveal the educational value of mobile app design activities and the web-based visual programming tool, and the possibility of teaching/learning mobile app design online. The findings can also encourage educators to explore and experiment on the potential of incorporating these design learning activities in their respective settings, and to develop mobile apps for their diverse needs in teaching and learning. This might include the production of web based programmes or modules that will help the learners to understand the basic principles of psychiatry.

- **Use of online teaching platforms:**

The use of online teaching platforms has been increasingly used in teaching various disciplines e.g. .literature, business and more recently, medicine. "Medical education is shifting away from traditional didactic methods towards a more self-directed learning environment. E-learning has emerged as a vital learning modality that allows students to apply key principles to practical scenarios in a truly personalised approach³". I have been involved in teaching psychiatry to undergraduate medical students and postgraduate doctors on an online teaching platform, through the OxPal project³. OxPal medlink is a novel, web-based distance-learning partnership designed to overcome some of the challenges to local medical education in the Palestinian territories.

OxPal tutors based in Oxford University Hospitals 'meet' with Palestinian medical students in the West Bank and Gaza weekly to participate in real-time tutorials. Clinical

cases from the students' own clinical experiences and those created by the tutor act as the focus. Tutorials involve discussion of these cases in order to develop skills in clinical reasoning, diagnosis and management. The virtual classrooms incorporate audio and text-based chat and an interactive white-board, facilitating a multimedia learning environment, requiring only low-bandwidth internet connectivity. This avoids the problem of restriction of movement in the occupied territories as students can access the tutorials from their homes. Student feedback on the programme was generally very positive. In online questionnaires, the vast majority of students rated tutorials as "excellent" or "good" and "very relevant" or "relevant" to their practice in Palestine. Students described the programme as "useful" and "really enjoyable" and commented that it "runs in parallel with the course at their universities"⁴. Although I haven't explored the students' learning experiences. At some point, I will assess their experiences according to the transformative theory and see whether that happened (Mezirow).

B. Setting up Reflection fora :

Encouraging specialist registrars in psychiatry to think, critique and reflect about their experiences at work and teaching would likely have a positive and enduring impact on their learning experience. This forum or group could be organised in a way that registrars could meet on a monthly basis to discuss various issues related to their clinical and teaching experiences. It would be great if we can generalise this idea so every teaching hospital or centre will have a dedicated venue and time for this group to meet regularly.

Enhancing Students' Learning Experiences:

Real audience:

I have shared the teaching plan with other academic tutors at the department of psychiatry who found it interesting and this has generated an interesting discussion as some tutors advised that their students preferred 'the routine didactic method' of teaching whereas others preferred this new method.

Peer-Peer teaching:

Medical students can be encouraged to engage in medical education of their peer colleagues. They can make use of online platforms to observe and teach other student colleagues in other UK universities or can expand internationally where they can teach other overseas students. The University of Alberta, Canada created 'Paedscases' which is a student-driven interactive website designed to achieve the learning outcomes identified by the competency-based paediatric curriculum. This open-access e-learning tool is a comprehensive peer-reviewed learning resource that incorporates various learning modalities. Material is student-generated and peer reviewed by staff paediatricians to ensure validity, accuracy and usefulness. "Paedscases is a collaborative resource created for and by medical students that provides an opportunity for active self-directed learning while disseminating knowledge in an evidence-based, interactive and clinically relevant fashion. Paedscases encourages students to take an active role in their education and drive medical education initiatives in response to the evolving curriculum³.

I am optimistic that such projects will have a positive impact on the quality of psychiatry teaching and training in Oxford and other deaneries at both under as well as postgraduate levels, in addition to enhancing the deep and transformative learning processes amongst learners.

Plan for implementation:

It was an interesting experience to try and devise this teaching plan for the academic and clinical tutors at the department of psychiatry, at Oxford university. Initially , I was feeling anxious about several aspects, including:

1. Acceptance by the university department leads.
2. Practicality of its use amongst tutors and learners.
3. Generalizability to other deaneries and schools of psychiatry.
4. Sustainability of its use over time.

In terms of familiarising this plan at a higher 'hierarchical' level, I had some anxieties about how a new teaching plan could potentially be implemented into a well-established and world renowned educational organisation like Oxford University. Dr O'Leary and I suggested using it to the academic lead at the department Dr Jonathan Price, who is in charge of the undergraduate teaching at the university department of psychiatry. Although he did not formally sign the invitation, he kindly agreed that this plan could be used by tutors who were undertaking the PGDipLATHE and were medical education fellows in Oxford in their capacity as academic leaders in their fields of medical education. I had a 'sigh of relief' that this plan was accepted and would be implemented at a departmental level. This ties in well with the 'Brains' and 'organisation' metaphors that we studied in June seminar (Morgan, G, 1997. Images of Organizations, Sage). Morgan's book opens with this question: "Is it possible to design organizations so that they have the capacity to be as flexible, resilient, and inventive as the functioning of a brain?". The university department could potentially be viewed as a human brain which has sets of neurons and connections with different people. The higher cortical structures 'head of department, and director of clinical education' would influence the end organ neurons 'students and learners' via some neuronal pathways 'academic and clinical tutors'. Tutors would deliver teaching and information under control (direct or indirect)

of the departmental leads according to specific curricula. This system could be flexibly managed so that students could lead their tutorials with experts inputs and make suggestions directly to the department. Morgan suggested that double loop learning in such organisations could be facilitated if certain principles were identified:

1. Encourage and value openness and reflectivity. Accept error and uncertainty.
2. Recognize the importance of exploring different viewpoints.
3. Avoid imposing structures of action. Allow intelligence and direction to emerge.
4. Create organizational structures and principles that help implement these principles.

At a personal level, I started to feel more comfortable with structuring my academic tutorials according to this teaching plan and I have noticed an improvement in the feedback given by students (learners) on my tutorials in general and my teaching style in specific.

Looking at the leadership frameworks we studied in the June seminar, it seems that we tried a few of them in implementing the educational change related to the teaching plan. That involved negotiations at a local 'tutors' level whereby the principle of creating organisational change (Scott, Coates and Anderson, 2008)⁵ was adopted such as creating clear priorities, involving staff and collaborative working. Priorities such as making sure that tutors covered all the major subjects covered in the curriculum in addition to ensuring that students acquired the relevant transferable skills which enable them to communicate safely and effectively with patients and colleagues.

Meeting the Tutors:

My supporting mentor, Dr O'Leary and I met with three the academic tutors in addition to one clinical tutor to publicise the 'proposed teaching plan' and some colleagues showed interest in adopting it in their tutorials. Dr O'Leary in his role as the lead of Oxford medical education Fellows invited the tutors to attend this meeting in February 2014 to familiarise the tutors with the new proposed teaching plan. Tutors largely agreed to use the plan in their following tutorials , give students more opportunities to lead the tutorial and give feedback about it. We met a week after that with the same tutors and had some interesting feedback about the teaching plan. Whilst I was more confident using the plan by that time, others thought they needed more time 'may be' to familiarise themselves with it. Some tutors use it with some flexibility i.e. they did not strictly follow the timing specified for each of the headings in the plan and that seemed to have gone well, too. A colleague tutor mentioned that some of his students' preferred a more didactic approach rather than the new method of teaching. However, all views were welcome and I really found these feedbacks very interesting and useful to me as a clinical teacher.

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Chapter VI

Ways to increase diversity and inclusivity

In the expanding world of technology , economics , and education, many countries have become multicultural with the continuing immigration and settlement of various ethnic groups all over the globe. UK has been one of these countries which attract different kinds of professionals including undergraduate students as well as postgraduates and specialists.

There is a growing body of evidence that increasing diversity and inclusivity at schools , colleges and higher education universities and institutes is associated with a better students' intellectual, personal and social development (Ambrose et al; 2004).

At an undergraduate levels, Oxford medical students come from a variety of ethnic backgrounds and over the years I have taught students who came from different parts of the world to study at Oxford (e.g. USA, Middle East, and Asia). These students brought to the tutorials interesting parts of their cultures and a nice example of that occurred when we discussed the cultural differences of how different countries perceive delusional thoughts and beliefs differently in addition to the interesting discussions of the culture-bound syndromes.

During the Michaelmas Term Investigation, it came out that some of the fifth year medical students whom I taught , underwent transformative learning as they were able to challenge their assumptions, think and reflect critically with a view of undertaking up new roles.

"The healthcare workforce is becoming increasingly international and globalised¹. In the United Kingdom in 2012, 37% of the doctors registered with the national medical

regulator, the General Medical Council (GMC), had qualified in other countries; 27% had obtained their medical degree from outside the European Economic Area (EEA)² . There are many medical professionals in the UK who have graduated overseas and their levels of English communication as well as clinical and cultural awareness of the British culture are very variable. I am currently working with in a scoping group set up by the dean of the Royal College of Psychiatrists to help supporting the International Medical Graduates (IMGs) to settle in their psychiatry training posts as well as looking at ways of improving their clinical skills and examination performance. IMGs have had lower rates at the Royal College examinations compared to local graduates and this has been seen in GP as well as psychiatry trainees.

Additionally, The General Medical Council (GMC) deals with a number of complaints and fitness to practice problems each year and the majority of the doctors concerned are IMGs.

All the above need a good amount of thinking and reflection. In my impression, IMGs are highly qualified medical doctors who were brave enough to leave their countries and families back home and come to practice medicine in the UK and of course facing many challenges e.g. with immigration, acculturation and working in the National Health Service (NHS). They all sat the GMC qualifying written and OSCE exams and were bright enough to pass them. In addition, there would be additional hurdles :

1. Cultural challenges specially for IMG doctors who come from non-European countries. these might constitute some additional sources of stress as they are settling into a new country while also doing a demanding job and trying to learn about local practices? Such cultural discrepancies might reflect in the way people view mental illness and some concepts like suicide and self harm. Whilst some cultures condemn suicide as a behaviour and consider it as a religious 'sin', others

might consider it in a different way. The IMG will need to be aware of such differences and concepts.

2. Language and communication differences: there is evidence that higher numbers of IMGs get referred to the GMC fitness to practice panels due to language and communication problems. In addition, "IMGs were more likely to obtain a less satisfactory outcome at ARCP compared with UK graduates³".
3. Assessment bias: one might argue that the poorer performance amongst IMGs might be related to the assessment processes undertaken by the deaneries or the Royal College of Psychiatrists e.g. written and clinical examinations.
4. Different undergraduate curricula: this is equally important as the other points as IMGs studied in different countries where the undergraduate curricula were possibly substandard or perhaps different from the British medical curricula.
5. Extrinsic factors : Professionals (e.g. trainers, colleague doctors and nurses) as well as patients might somehow scrutinise the IMG for a variety of reasons (e.g. based on their language and communication, or subconsciously stereotyping the IMG based on their ethnic background).

The way forward: This is not an easy project but rather a collective effort from different agencies and stakeholders e.g. colleges, deaneries and hospitals. I can visualise some concepts that could potentially be used to increase inclusivity and promote diversity in the population of IMG psychiatrists:

- Language and vocal coaching: I can talk from a personal experience where I benefited a lot from attending coaching sessions with a language coach in the first year of my psychiatry training. I have recommended this to the Royal College's scoping group and this suggestion was well received by the group.
- Raising cultural awareness : we have to encourage IMGs attending these workshops which can be organised by the colleges or deaneries or even local trusts. There are some pioneering examples in this field. These will enable postgraduate trainees to effectively work with their patients of British origins. I can talk about this from my experience where I found these coaching sessions and workshops very important in knowing what to say and how and when. I have found that problem base learning that can be facilitated in small group teaching has a very powerful learning effect. This has been a flourishing idea since 1960s (Neufeld and Barrows, 1974). Problem based learning has become an integral part of under and postgraduate medical education in the UK. International Medical Graduates can be enrolled in workshops that augment their beliefs in their skills and strengths as well as encouraging them to reflectively think about how they can deal with patients from different cultures. In addition, these cultural awareness workshops or sessions could be offered to British trainers and professionals to make them more aware of different cultures , so as to better interact with their culturally diverse colleagues , patients and the increasingly diverse British communities. The Oxford deanery is one of the pioneering deaneries in offering these workshops to their IMGs with a view of including trainers, too. Interestingly and as I write this piece, I am attending a Royal College conference tomorrow that is aimed at supporting IMGs.
- Promoting deep learning: by not only aiming at improving examination performance but heightening the learners beliefs and expectations about their capabilities (Bandura, 1997). These graduates are highly qualified in their

countries and it would be a shame if they will be functioning at a lower level below to what is expected from them. An American study "sought to develop a curriculum for international medical graduate (IMG) psychiatry residents that addresses their culture-based deviations from normative boundary-keeping practices common to U.S.-based psychotherapy practices. International medical graduates confidence levels regarding psychotherapeutic boundaries can be significantly increased through participation in a curriculum that addresses cultural differences⁴".

- Feedback: Many IMGs welcome direct feedback on their clinical and communication skills so as to improve these aspects and we can ask their trainees, supervisors and colleagues to give them constructive and timely feedback keeping in mind the potential unease that some of them might have because of this feedback which might occasionally be construed as criticism. Learners from other countries might negatively accept the feedback and think of it as criticism whereas constructive feedback is very important in their development.

Institutions of higher education must create interventions that maximize the benefits of inclusion by challenging students to think critically about their assumptions, seek out knowledge, and develop informed perspectives (Gurin, Dey, Hurtado, &Gurin, 2002).Psychiatry training programmes in the UK contain a diverse collection of postgraduate doctors from many ethnic backgrounds (e.g. Asia, African, and East European) in addition to British and Irish counterparts. Many of these doctors graduated in overseas countries and they have different under and postgraduate medical curricula.

One important factor that can be implemented to mitigate unintentional biases is being aware of these biases and various measures can be implemented like attending diversity

courses and simple exercises like the ones we did as part of our preparation for this module. The Royal College of Psychiatrists examination department has been at times criticised by some International medical Graduates that examiners at OSCEs positively favour white British doctors who score higher compared to other graduates. The college has been keen to address any issues related to unintentional biases and to ensure gender and ethnic equality. I am recommending that the Royal College of Psychiatrists CASC examiners undergo the exercises on the unintentional biases exactly as PGDippers did earlier in the year prior to March seminars. "Acknowledging biases often opens doors for learning and allows people to consciously work for harmony in classrooms and communities⁵". "The Implicit Association Test (IAT) developed at Harvard measures the hidden attitudes and beliefs that determine our preferences for certain groups over others. It uses images flashed on screen which participants match with a list of words, some carrying positive and others negative associations, to test a wide range of possible biases, including age, gender and race. The outcome measured is not the actual association reached but the time taken to reach it. It is common, for example, for participants to take longer to identify images of BME people with positive rather than negative words than it takes them to similarly match images of white people. The implication is that, in a situation like this, where we know that our views are being tested, we are taking the time to use our conscious mind to mitigate the impact of buried bias. So the IAT not only demonstrates that we are biased, but that mindfulness (exercising our conscious mind) can help to mitigate bias".

One way to overcome this is to have external observers who would sit observing the flow of the examination interview and ensure that the candidate is correctly marked.

Finally, my reflection is that this task was an interesting one for me and that I have found it really challenging to write 2000 words about this subject despite the fact that it is very close to my heart and I think that I could do more to support IMG colleagues.

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Appendix 1: MTI Interview Questionnaire

	<p>Is there any way in which what you learned changed the way you do your job?</p>	<p>Can you give me some examples? (prompt if necessary)</p>	<p>What was it about the course that helped you realiseX..... or change inY.....</p>	<p>How would you describe your learning experience on this course [programme/rotation]?</p>	<p>What do you understand by <i>reflective practice</i> and how do you use it for your own learning?</p>
Mezirow's 10 Phases					
Disorienting dilemma					
Self-examination					
Critique of assumptions					

Options for new roles/relationships/action					
Planning a course of action					
Acquisition of knowledge and skills for implementation					
Trying of new roles					
Building competence in new roles and relationships					
Reintegration with new perspective					
Practice of transformative learning					
Purposeful (learners					

act on their world for change)					
Confronting power and engaging difference					
An imaginative process (<i>"reweave new patterns of meaning"</i>)					
Leading learners to the edge – direct learning experiences or complex, and emotional responses					
Fostering reflection					
Modelling by teacher					

Appendix 2: MTI results:

<p>Interviewee: MS...</p> <p>Date of interview: 10 December 2013</p>	<p>Is there any way in which what you learned changed the way you do your job?</p>	<p>Can you give me some examples? (prompt if necessary)</p>	<p>What was it about the course that helped you realiseX..... or change inY.....</p>	<p>How would you describe your learning experience on this course [programme/rotation]?</p>	<p>What do you understand by <i>reflective practice</i> and how do you use it for your own learning?</p>
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	<p>Yes, what I learnt in psychiatry has changed the way I perceive how I see people e.g. in Cowley Road where I live. I am more aware of the background now. I have met a range of people during my psychiatry placement. I learnt to look at people more holistically. I will be very disappointed with myself if I lost that. When you come</p>	<p>I met many patients in the inpatient wards and have met some of them in Cowley road whilst they are on leave. You realise, it's more than a MH problem, there is a back story with children and families. This is not like the real GP surgery in Cowley road, and there was</p>	<p>Aha moment. Hearing people stories is very powerful either in the context of being on the wards e.g. Littlemore, patient with Korsakoff. Conversation with someone and acute psychotic, had the conversation, enjoying my time in conversation and that's a real revelation. That's one. Another one, one of the lectures, 15 years</p>	<p>It was very good. It combined the theoretical and practical aspects of psychiatry. E.g. having a tutorial on schizophrenia and then seeing someone with schizophrenia is a very helpful way of doing it. There could have been General adult psychiatry placement: the placement was fairly unsupervised, you come to the wards and it was</p>	<p>OK. Taking time thinking about why I did things and why I feel about doing that. e.g. I see an interesting patient (someone who has severe depression and can be distressing for me, or a child with autism): you go and think why I feel that way and why has that affected me. Part of it is reflection by telling a</p>
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	<p>across situations. Different perspectives more universally applicable</p>	<p>someone acting weird and people might ignore him. When I look at people from different perspective.</p>	<p>old anorectic who was asked to do an interview with some of us. That was very amusing. These were the kind of people I knew 10 years ago or could be the children of my friends 10 years from now.</p>	<p>unplanned. You might interview someone. It would have been better with more supervision. In child psychiatry, you were very much welcome to the team , and you can feel you were doing something. you feel part of the team, being more productive (that kind of inclusion).I liked the child psychiatry more than the general adult. Ideally, I like the clinical side</p>	<p>story.When things are taken for granted or challenged. I think assumptions. Underlying assumptions. You meet someone and then you make a snap judgment of their appearance and then you realise that that wasn't true. I remember a patent with drug induced psychosis, and</p>
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				<p>of practice. I aim to have more practice.</p>	<p>has very negative conceptions about things.</p> <p>I probably haven't formalised this yet but it could be still in the background.</p> <p>Thank you very much Mike.</p> <p>We'll do a presentation and might publish the results. It will be nice to see your paper.</p>
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<p>Interviewee: HK</p> <p>Date of interview: 17 December 2013</p>	<p>Is there any way in which what you learned changed the way you do your job?</p>	<p>Can you give me some examples? (prompt if necessary)</p>	<p>What was it about the course that helped you realiseX..... or change inY.....</p>	<p>How would you describe your learning experience on this course [programme/rotation]?</p>	<p>What do you understand by <i>reflective practice</i> and how do you use it for your own learning?</p>
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	<p>In psychiatry in particular? Ah, more attention to our patients. Yes I guess. Forming clinical judgments.</p>	<p>Q2. In psychiatry. Let's see. Psychotic depression, generalised problems. More empathetic in dealing with patients</p>	<p>A patient with depression, she was psychotic in pregnancy, My experience in psychiatry has benefited me in dealing with other patients Aha moment 'insight learning': I can't exactly think of this right now.</p>	<p>It was beneficial, Physical and Clinical examination,</p>	<p>Actually, thinking about new experiences and yes I used it in my practice Yes, I suppose, it helped me in neurology, psychiatric illness</p>
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<p>Interviewee: JL</p> <p>Date of interview: 18 December 2013</p>	<p>Is there any way in which what you learned changed the way you do your job?</p>	<p>Can you give me some examples? (prompt if necessary)</p>	<p>What was it about the course that helped you realiseX..... or change inY.....</p>	<p>How would you describe your learning experience on this course [programme/rotation]?</p>	<p>What do you understand by <i>reflective practice</i> and how do you use it for your own learning?</p>
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	<p>Er, the approach towards somatoform disorder, before I was more dismissive of them .Certainly this applies to people attending A&E, try to think of their psychological makeup and background. Try to manage the psychological aspect.</p>	<p>More comprehensive risk assessment of patients of patients coming to the door, mainly risks of suicide, and harm to others, risks of self neglect in addition the risk of financial exploitation.</p> <p>Look more holistically at people, yes, acknowledging</p>	<p>Being on PICU (Psychiatric Intensive Care Unit) has helped me undertake a good risk assessment. I have seen many patients with thought disorder where as I didn't see many patients before.</p> <p>Insight learning/transformational learning theory: Er, thought disorder , delusions and other jargons.</p>	<p>It was quite good. Clinical skills I learnt are 'transferrable', getting involved in presenting clinical cases, more comfortable dealing with cases</p> <p>Academic tutorials; they were a bit hit and miss. The tutor wanted us to pick things up.</p> <p>Anyway we could improve? It's probably better to divide the work between the</p>	<p>Going to do something and then think about what you've done and what lessons you've learnt. We kind of do it in quite an informal way 'or unconscious' when we present patients, might go home and think of some patients .Then we can reflect on what we've done well and how we can do better. In</p>
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		the psychological aspect.		students.	terms of what I do myself; I find it a lot harder to do it myself if I am not helping someone to reflect. Acquisition of skills : yes the course has helped me in that.
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<p>Interviewee: CB</p> <p>Date of interview:18 December 2013</p>	<p>Is there any way in which what you learned changed the way you do your job?</p>	<p>Can you give me some examples? (prompt if necessary)</p>	<p>What was it about the course that helped you realiseX..... or change inY.....</p>	<p>How would you describe your learning experience on this course [programme/rotation]?</p>	<p>What do you understand by <i>reflective practice</i> and how do you use it for your own learning?</p>
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	<p>Made me more patient, more patient, more listening, and talking at times. Long term, I never considered psychiatry as a choice for a future career where as now, It's amongst my choices.</p> <p>Hopefully , the skills I learn will stay with me in the different specialities.</p>	<p>In terms of relationships. Seeing a psychiatric patient is different from others, e.g. florid psychosis and delusions. Taking history from these patients can be challenging. Many of these people had a trouble past. This took me out of my comfort zone,</p>	<p>In the course, throughout the course. You have to go and get assessed by the consultant. That was helpful. You have to go and ask the patient specific questions will help you more than reading form the book.definitely enough realistic history from real patients. Video is onlya video</p>	<p>Good, yes good. I liked the clinical and the theoretical structure of exams unlike other specialities. Working in 2 different psychiatric specialities helped me understand how each specialty is run. How it could be better run, the only way is to include real patients although that might not be viable as it might need consent.</p>	<p>Seeing patients, it will change the way I approach things or patients, mainly applies to clinical rather than academic settings.use it may be not officially. I thought of some patients when I went home, definitely Yes definitely, clinical Trying to work out the diagnosis</p>
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		might be silly. Seeing patients with previous sexual assault and seeing beyond that (specially forensic units)		Academic tutorials were great, know about the topic.	
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<p>Interviewee: CB</p> <p>Date of interview:18 December 2013</p>	<p>Is there any way in which what you learned changed the way you do your job?</p>	<p>Can you give me some examples? (prompt if necessary)</p>	<p>What was it about the course that helped you realiseX..... or change inY.....</p>	<p>How would you describe your learning experience on this course [programme/rotation]?</p>	<p>What do you understand by <i>reflective practice</i> and how do you use it for your own learning?</p>
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	<p>Made me more patient, more patient, more listening, and talking at times. Long term, I never considered psychiatry as a choice for a future career where as now, It's amongst my choices.</p> <p>Hopefully , the skills I learn will stay with me in the different specialities.</p>	<p>In terms of relationships. Seeing a psychiatric patient is different from others, e.g. florid psychosis and delusions. Taking history from these patients can be challenging. Many of these people had a trouble past. This took me out of my comfort zone,</p>	<p>In the course, throughout the course. You have to go and get assessed by the consultant. That was helpful. You have to go and ask the patient specific questions will help you more than reading form the book.definitely enough realistic history from real patients. Video is onlya video</p>	<p>Good, yes good. I liked the clinical and the theoretical structure of exams unlike other specialities. Working in 2 different psychiatric specialities helped me understand how each specialty is run. How it could be better run, the only way is to include real patients although that might not be viable as it might need consent.</p>	<p>Seeing patients, it will change the way I approach things or patients, mainly applies to clinical rather than academic settings.use it may be not officially. I thought of some patients when I went home, definitely Yes definitely, clinical Trying to work out the diagnosis</p>
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		might be silly. Seeing patients with previous sexual assault and seeing beyond that (specially forensic units)		Academic tutorials were great, know about the topic.	
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<p>Interviewee: JP</p> <p>Date of interview: 18 December 2013</p>	<p>Is there any way in which what you learned changed the way you do your job?</p>	<p>Can you give me some examples? (prompt if necessary)</p>	<p>What was it about the course that helped you realiseX..... or change inY.....</p>	<p>How would you describe your learning experience on this course [programme/rotation]?</p>	<p>What do you understand by <i>reflective practice</i> and how do you use it for your own learning?</p>
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	<p>It changed how I act in general.get to know different manifestations particularly in A&E when you see people with Deliberate self harm (DSH), dementia; helped me understand how people live. Better understanding of MHA (Mental Health Act).</p>	<p>Anything: now and when if I see a depressed patient, always ask about the evolutionary history.</p>	<p>I Realised how psychiatric illness is quite common, specially suicide and DSH. Knowledge of how common it is.alcohol and drug abuse too. Definitely feel more confident when dealing with people in medical and A&E units</p>	<p>Acquisition of knowledge and skills happened. The time I spent with patients had helped me a lot. This happened to me lot In psychiatry, it feels more real, you feel a lot with the patients, try to feel what a psychotic patient feels, I remember their names, what condition, their smell, look..etc</p>	<p>How did I do and what could I do better, patient with psychosis, treat with antipsychotics, helped me formalise my thoughts.</p>
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Aims of the interview

- To explore your learning experience during your recent face-to-face teaching at Oxford.
- To identify what you value most and least about this learning experience and the elements that had an important effect on what you learnt.
- To contribute to the evidence about the effects of different teaching approaches on learning outcomes.
- To improve our approach to teaching.

Please be as **candid** as possible during the interviews. We are not testing you, but are simply aiming to learn more about the effects on student learning from the way we teach.

Important points to note

- The interview will be recorded and transcribed to enable us to analyze your responses in detail.
- Information kept in confidence
- The recording and any transcript will be destroyed at the end of 2014
- All transcripts will be anonymized before being shared with our co-researchers
- We hope to publish our findings at the end of the course but there will be nothing that will enable you to be identified.
- Please let us know if you would like a copy of our report.



Who are we?

We are a group of three established teachers at Oxford, from different professional backgrounds, who are undertaking a Post-graduate Diploma in Learning and Teaching in Higher Education to improve our understanding of learning theories and our teaching methods.



We are working on a joint project for one of our assignments which requires us to interview some of our students in depth to understand their learning experience. We plan to compare responses across the disciplines and look for commonalities. We would like to publish our findings to contribute to the evidence about effective learning.

Appendix 4: Examples of students' feedback

<p>Before the implementation of the new teaching plan:</p>	<ul style="list-style-type: none">• Very friendly and approachable for students. Willing to give a lot of teaching.• Perhaps a bit more structure during the tutorials. Perhaps knowing the topic to prepare the previous week and discussing this in the tutorial.
<p>After the implementation of the new teaching plan:</p>	<ul style="list-style-type: none">• Excellent at facilitating discussion and answering questions. Good use of personal experiences to illustrate teaching points. Happy to give advice and answer questions beyond the scope of the curriculum. Good feedback.• Dr Al-Taiar fostered an atmosphere of discussion within the tutorial group that made for an excellent learning environment. • Lots of interactive group work.• Not didactic enough for me• Very kind doctor, with an extensive knowledge and skill-base (which

he passes on effectively to students)!

- Became much better towards the end when we changed the format and had a med student prepare a topic and lead the discussion with others contributing,
- Small group teaching worked very well. Dr Al-Taiar helped to facilitate group discussion and clarify points where necessary.
- Dr Al-Taiar was mostly facilitating our discussions which a different member of the group lead each week. This worked really well, and allowed us to explore subjects as we please.

