## Changing medical students' attitudes about mental health

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**What problems were addressed?** A lack of integration of mental health topics in the curriculum and insufficient interaction of students with patients were identified by a 2009 internal school report. It is well known that public attitudes towards mental health patients and psychiatric treatment can be prejudicial.[1] This becomes more relevant as psychiatric patients are more likely to be in contact with general physicians, according to Brazilian mental health policy. The medical school's goal is to graduate general doctors skilled to work in primary health care and in general emergency settings. From a pedagogical perspective, the medical school's approach is students-centred, problem-based and community and health system-oriented. The challenge was how to address this discrepancy. Since 2003, the curriculum had included mental health, medical psychology and psychiatric topics, but these subjects have not been fully implemented.
**What was tried?** A multidisciplinary faculty group, responsible for developing the learning strategy in a course, 'Medical Practice in the Community', partnered with the local community mental health system, which is directly linked to the primary health care system. This group created a strategy for developing a mental health community-based practical experience for first-year medical students. The resulting learning strategy was aligned with both the curriculum plan and the mental health service's guidelines and needs. The main objective was to address the barriers and stigmatised perceptions of students towards mentally ill patients and to develop more emphatic attitudes towards them. Eighty first-year medical students were divided into four groups and attended the 'Medical Practice in the Community' course at therapeutic workshop community centres for 8 weeks. Students participated in a total of 32 hours of on-site activities with patients; these included interviews, informational workshops on general health topics and therapeutic recreation. In addition, they spent 16 hours in academic group discussions studying short videos, literature and scientific papers. This educational project was designed in cooperation with mental health authorities and service managers where the practical activities took place. All the main contributors participated in evaluating the programme: faculty members, students and services' managers. Surveys, observation and group discussion provided comprehensive feedback from all viewpoints.
**What lessons were learned?** The results of the evaluation indicated that a collaborative approach providing early exposure to mental health care for first-year medical students contributes to the humanistic education of future doctors. From an ethical point of view, this process considers human diversity, develops coping skills with people with severe mental disorders, creates familiarity with the health care system and stimulates reflection and critical skills of students. Our experience shows that effective, broad-based collaboration can successfully combine achieving educational objectives with delivering community-based health care. This intervention is the first of three increasingly more complex mental health segments that will be developed as two later modules of the medical curriculum during the fourth and last years of the course.

REFERENCE

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## Coaching the coaches: targeted faculty development for teaching

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**What problem was addressed?** In daily practice, our emergency doctors are asked to document some of the formative feedback that they give to residents as part of ongoing clinical assessment in the workplace. However, few of these preceptors demonstrate best practices when writing formative feedback. This has led to a culture of feedback where vague, non-specific suggestions ('good work') are found more often than advice that is specific and constructive enough to lead to behavioural change in the learner. Preceptors give good verbal coaching in the workplace ('Next time you get consent for a lumbar puncture, discuss infection risk'), yet do not write down that very coaching. The result is that when residents reflect back on feedback received during a rotation, only a smattering of useful advice is available amidst nebulous comments masquerading as feedback.
**What was tried?** Ten clinical preceptors volunteered to have their written feedback analysed, and to then undergo a one-on-one faculty development session. On average, preceptors documented three discreet pieces of feedback during a shift with one resident. On average, only 30 pieces were required to reach saturation of the advice to give to each preceptor.
The feedback was analysed using a 5-point scoring system that we developed from the literature on good formative feedback (validated tool to be published; created 2010, validated 2012; inter-rater reliability 0.94). Feedback had to be specific, informative, and contain enough information to allow the resident to recall the feedback event. The best feedback, containing all five elements, could also be identified by the fact that a resident could reflect on it at a future date and reproduce their correct action or behaviour or make necessary correction.
Preceptors were coached in 30–45 minute one-on-one sessions and were provided with individualised instruction (based on their own written feedback) on how to improve their written feedback. Discussions took place in which each participant voiced questions and concerns about