Introduction

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Drawing on case studies, updated papers from *BJPsych Advances* and specially commissioned new chapters, this book takes a scholarly approach to the whole range of teaching and learning as applied to psychiatry. This covers direct teaching of the speciality of psychiatry through to educational management, coaching and mentoring. It provides essential information on topics not often covered, and it will provide guidance for busy clinicians who are acting as trainers, and for those who teach and train medical students in university departments.

Many of the chapters are written by figures of significant educational status within clinical psychiatry. These include a new chapter on literature searching; chapters on technological aspects of teaching such as webinars and virtual placements (the importance of which has been brought into focus by the recent effects of the pandemic on how training is organized); and writing for learning and publication.

Teaching teachers how to teach is a neglected topic in medicine generally and this book aims to fill this vacuum with accessible and clearly written material on basics such as how to deliver a ‘good’ lecture, how to run a webinar, how to make ‘Powerpoint’ interesting and how to gain access to up-to-date information without feeling overwhelmed. Before and after COVID-19

This book was conceived before the coronavirus (COVID-19) pandemic which has so dramatically transformed the clinical and training lives of so many doctors. Before this event there were already many concerns about the welfare of trainees (not just psychiatrists) in clinical environments. This theme is addressed in this book in a way that may be helpful: no longer should it be seen as stigmatizing to admit that you are struggling in your working environment. The new chapters on coaching and mentoring and how best to support trainees in difficulty remind us of the importance of the human connection between trainers and trainees.

Virtual clinics and virtual conferences and meetings are good examples of some of the developments that trainers and trainees were obliged to adopt when the pandemic struck in 2020. How reassuring it was at that time to watch the webinars rapidly produced by the Royal College of Psychiatrists. We are yet to see how many of the changes made to accommodate remote teaching and learning will remain (probably quite a few). Professor Subodh Dave, now Dean of the College, along with colleagues, was also instrumental in helping many of us come to terms with virtual teaching, very soon after the start of the pandemic, through informative webinars suggesting imaginative strategies broadcast from the Association of University Teachers of Psychiatry (AUTP). A new landscape of technical terms of engagement has emerged including being ‘on mute’; how to raise your virtual hand and remembering to lower it again; and those comments about ‘it’s in the chat’. And what to

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do about ‘lurkers’ (i.e., those who seem to be at the meeting but make no contributions). Other ways of harnessing technology have been demonstrated by the use of smartphones and portfolio-based learning and e-learning.

However, for psychiatrists who are always attentive to the non-verbal cues in the consultation and mindful of what is going on off camera, the exclusive use of telephone calls and video clinics, common modes of consultation during the pandemic, are always going to limit the possibilities of human interaction in the here and now.

All of these developments highlight the importance of continuous professional development (CPD) for the trainer and many of the chapters in this book return us to sound principles on how to deliver a good lecture, involve patients in teaching, consider assessment, supervision, feedback, small- and large-group learning, critical reflection and the use of journal clubs and workshops. This was the staple of learning for many of us as we matured into competent clinicians, teachers, trainers and academics.

Topical Developments in Medical Education and Psychiatry

Two immediate and two more remote topics deserve particular mention here. The two immediate ones are the expansion of the foundation programme in psychiatry and differential attainment.

The foundation programme in psychiatry has been a topic of much interest in the College and has also been the focus of national reviews. In Chapter 15 of this volume, Das and colleagues bring us up to date with the developments and inform us of the recommendations that have been made for foundation trainees and also for those trainers supervising them. The ambitious plans for the expansion of psychiatry posts in the foundation programme will have a large impact on the number of doctors who will have had some grounding in the specialty and, we hope, a more favourable attitude towards it. They also of course have an impact on supervisors: often keen to train but always struggling to find extra time to support trainees.

Whilst not the subject of a dedicated chapter, differential attainment is described in Chapter 2 by Greening et al. on the Membership of the Royal College of Psychiatrists (MRCPsych) courses and also Chapter 22 by Huline-Dickens on trainees in difficulty. It is still the case that some supervisors are unfamiliar with the term and literature on this important subject, in spite of the fact that so many of our trainees are international medical graduates who may miss out on opportunities and often need more support with some aspects of their training.

The two slightly more remote topics are the introduction of the new UK Medical Licensing Assessment and the increasing emphasis on patient safety. Although not a focus of this book it will be relevant to many trainers to know that, from 2024, there will be a requirement for international medical graduates who would have sat the Professional and Linguistic Assessments Board test (PLAB), as well as all UK medical students, to sit a licensing exam, the UK Medical Licensing Assessment (UKMLA). This will consist of an applied knowledge test (AKT) and clinical and professional skills assessment (CPSA).

Educating for patient safety is another topical area, and simulation is a good way to teach this. The World Health Organization (WHO) have produced a curriculum guide, Patient Safety Curriculum Guide (WHO 2011), and many other resources are available to support teaching and training with patient safety in mind such as the Institute for Healthcare Improvement or the National Collaborative For Improving the Clinical Learning Environment (NCICLE).
Psychiatrists are uniquely placed to understand systems, apply human factors approaches, engage patients and families and use knowledge of team dynamics to this end.

The Teaching and Training Roles of the Psychiatrist

As psychiatrists we have many roles within training and in the arena of the scholarship of teaching and learning. Many colleagues will have been introduced to teaching or training when asked to supervise trainees or medical students early in their career, and have been confronted with the need to master the material they teach and also communicate it in a way that is engaging. Seeking feedback, reflecting on this and adapting resources and refining the goals for the session, and the methods of presenting these, are activities that quickly follow and form the basis of scholarly teaching.

Over the careers of the two editors of this book, the roles and activities of academically inclined psychiatrists have changed dramatically: where once we had clinicians who were doing teaching merely as an additional activity, some more expertly than others, academically minded doctors now have the possibility of pursuing teaching as a portfolio career available to them. Teaching has become professionalized and time needs to be included in job plans to do it.

The Professionalization of Teaching and Training

Many colleagues will have been aware of the increasing trend towards professionalization of teaching, and this is mentioned in Chapter 17 by Ingrassia and Batham. In this context too it is interesting to reflect on the work of Boyer (1990) and his work Scholarship Reconsidered: Priorities for the Professoriate. In this, he distinguished four categories of scholarship: application, discovery, integration and teaching. Not everyone will wish to engage with all levels, but institutions would do well to support individuals who do. Scholarship thought of broadly is the ability to think, communicate and learn.

Colleagues interested in teaching should bear in mind the helpful distinction drawn by Cleland et al. (2021). These authors distinguish scholarly teaching from the scholarship of teaching and learning. Within this document, the guide produced by Association for Medical Education in Europe (AMEE), ‘Redefining scholarship for health professions education: AMEE Guide No. 142’, they describe the importance of the scope of influence one can have as an experienced clinician and educator spanning different institutions.

According to these authors, scholarly teaching uses the work produced by others (the literature) to inform and guide one’s practice. Scholarly teaching involves reflection and observation of one’s teaching, curriculum design, development and maintenance, and evaluation of practice and has a pragmatic focus. The scholarship of teaching and learning, on the other hand, is the systematic inquiry into student learning which advances the practice of teaching and is likely to involve research and dissemination, and to advance the profession of teaching itself. Cleland et al. believe that every teacher should work towards becoming a scholarly teacher, but every scholarly teacher need not engage in the scholarship of teaching and learning.

For those new to either category, learning on the job is available through courses and conferences offered, among others, by the Association for the Study of Medical Education (ASME) and Association for Medical Education in Europe (AMEE). These international organizations are communities of practice (a term coined by Lave and Wenger 1991) and
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offer activities and resources for members supporting scholarship. Colleagues can also study education through Certificate, Diploma and Masters’ programmes.

We believe this textbook will fill a vacuum for teachers of psychiatry, whether they are clinicians using their experience to enhance the knowledge of medical students, or trainees in psychiatry. Teaching and imparting knowledge is also an excellent way of learning and of continuing one’s own personal and professional development. So here’s to a long life of learning. In the words of Michelangelo (aged 87), ‘I am still learning’.

References


Section 1

Teaching and Preparation

Chapter 1

Improving Patient Care through Continuing Professional Development

Guy Brookes

Introduction

Medicine is a rapidly developing field. Much of what many of us learned in medical school is now obsolete, and an expanding knowledge base has led to increasingly specialized services. If you add to this the fact that many doctors – by choice or as the result of service changes – change their areas of clinical practice, the need to continue learning and developing after completion of formal training is undeniable.

We learn on a day-to-day basis in our clinical practice. As well as taking the relatively obvious forms of reading a literature review or asking the advice of a colleague, learning will also be through continuous feedback, for example from patients about a particular approach we take or a good clinical outcome. Being open to everyday feedback and thoughtfully working in teams is therefore an important part of remaining a safe and effective practitioner.

Given this essential and unavoidable day-to-day learning, it is reasonable to ask what the additional benefit guidance from the Royal College of Psychiatrists and Academy of Medical Royal Colleges alongside requirements set out by the General Medical Council (GMC) add.

What Is Continuing Professional Development?

The General Medical Council (GMC) has defined continuing professional development (CPD) as follows:

CPD is any learning outside of undergraduate education or postgraduate training that helps you maintain and improve your performance. It covers the development of your knowledge, skills, attitudes and behaviours across all areas of your professional practice. It includes both formal and informal learning activities (GMC 2012).

This definition acknowledges the continuous learning within clinical practice described above and the importance of this in a doctor’s development. It emphasizes that CPD should consider the full scope of a doctor’s practice and that, while the majority of psychiatrists are primarily clinicians, other roles such as teaching or research, must not be forgotten.

The College’s CPD programme supports a structured and objective approach to learning and seeks to make CPD more effective for the individual. It does not aim to encourage the doctor to record and explicitly consider all learning that they undertake. This would be unrealistic and would not reflect the way in which thoughtful practitioners develop. Key to the College’s programme is the development and completion of a personal development plan (PDP) within a CPD peer group that can support the doctor in reflecting on current practice (and therefore areas for development) and the implications of new learning for their practice.
If CPD is intended to help ‘maintain and improve your performance’, it is reasonable to assume that the outcome of good CPD is improved patient care. This makes intuitive sense but, although it is possible to show evidence of improved outcomes individually, demonstrating that CPD as a whole improves care is far more challenging (Mathers 2012).

What Are the Requirements for CPD?

There are three bodies that provide guidance or requirements for psychiatrists’ CPD. This can lead to confusion if their roles are not understood.

1. The General Medical Council

The role of the GMC is set out in the Medical Act 1983. It maintains a register of doctors ensuring appropriate qualifications, sets standards for a ‘good’ doctor, including undergraduate and postgraduate education, through revalidation ensures that doctors keep up to date with knowledge and skills and, if needed, investigates concerns raised about doctors. Therefore, though it seeks to improve practice, the GMC is there to ensure a minimum and safe standard. In keeping with this, there is a requirement for annual appraisal to ensure that doctors are keeping up to date and in line with the standards set out in Good Medical Practice. There is no minimum amount of CPD required and demonstration that you have met the standard is through annual appraisal and ultimately revalidation.

2. The Academy of Medical Royal Colleges

The Academy of Medical Royal Colleges seeks to ensure standards are consistent across the many specialties in medicine. This is similar to the role of the GMC in that it is essential that the public has equal confidence in a general practitioner as a psychiatrist or a surgeon. The Academy of Medical Royal Colleges is essentially the product of its constituent colleges and so its guidance applies to all colleges but focuses on areas that are universally applicable. As such it has defined seven core principles of CPD:

(1) Individual responsibility. In line with the GMC, whatever support is in place (e.g., appraisal, CPD peer groups), doctors, themselves, are ultimately responsible for maintaining and improving their practice.

(2) The importance of reflection. Learning has no value unless considered against current practice and the opportunity for improvement.

(3) Scope of work. All areas of a doctor’s role need to be considered. Realistically this cannot (and might not be desired) be completed every year but needs to be covered within the five-year cycle.

(4) CPD and annual appraisal. CPD undertaken within the year should be considered within the annual appraisal but identifying development needs should not be limited to this annual event.

(5) Balance of CPD. Different learning approaches offer different benefits. It is important to have opportunities for learning outside organizations to broaden experience and learn with colleagues as well as alone.

(6) Documenting CPD. It is essential that doctors are able to evidence learning undertaken and the consequences of this.

(7) Employers’ responsibilities. Doctors need access to funding and time to keep up to date and develop their practice.
3. The Royal College of Psychiatrists

The College is the professional body responsible for supporting psychiatrists throughout their careers and setting and raising standards. It thus promotes our development.

Guidance from the College therefore focuses on improvement and specifically relates to psychiatrists’ needs. Our guidance differs somewhat from the Academy of Medical Royal Colleges while adhering to the shared principles. For example, while the Royal College of Psychiatrists has set a minimum of 50 hours of CPD each year approved by the CPD peer group, not all colleges (as with the GMC) do so there is no quantity required by the Academy of Medical Royal Colleges. The range of specialties and different needs across the profession means that it is the CPD peer group rather than educational providers that determines whether any learning has been effective for an individual. As a result, to be in good standing with the College for CPD requires active engagement with the CPD peer group.

Because the College’s requirements for being in good standing for CPD differ from those set out by the GMC, being in good standing is not necessary for annual appraisal and thus revalidation.

How to Link CPD to Improved Patient Care

Good CPD can have many potential outcomes – for example, improved confidence, greater job satisfaction, innovation, networking and sharing with peers – but the ultimate outcome should be improved care for patients. How can this be achieved?

Developing a Focused PDP

As doctors, we receive feedback from many sources. Some sources are formal, such as complaints, incident reviews or structured multi-source feedback; others are less formal, such as individual patient outcomes, peer discussion and our own reflections on our practice. Being able to consider this feedback honestly and thoughtfully is essential to understanding our learning needs. When developing a PDP, it is natural to be drawn to our areas of interest or expertise. Of course, to stay up to date, ongoing learning in such areas is necessary but we must also pay attention to areas of our practice that we are less enthusiastic about and have perhaps not focused on previously.

It is the individual doctor’s responsibility to identify their needs and consider how they will address them (GMC 2012). However, psychiatrists are helped to do this in two ways: by their CPD peer group and by the appraisal process.

- The peer group will use an informal process to help the doctor to develop a PDP that reflects their needs (rather than interests or wishes).
- At appraisal, information about the full scope of the doctor’s practice and performance (e.g., outcome measures, complaints, incident reviews, activity levels) is formally discussed. Using this information as a foundation, the appraiser and doctor will create a PDP. The full scope of practice – both clinical and non-clinical aspects – should be considered.

This can mean that the doctor ends up with two PDPs: one from the peer group and one from appraisal. The PDP developed in the peer group will inform the one developed in appraisal. If the processes resulting in each have been robust, the PDPs should not be too dissimilar. A significant difference in the PDPs should raise concerns that there has not been
fair or honest discussion about the psychiatrist’s work and needs in one, or both, of the processes.

It is important that CPD reflects the doctor’s practice (or intended practice for the future), rather than their own personal interests. Although all doctors, whatever their experience, need to stay up to date with relevant therapeutic developments, it is inevitable that their needs will change over their career. Developing skills that are not going to be used in practice will not benefit patients.

Successfully Addressing Development Needs
To evaluate how successful learning has been, it is necessary to be clear about what is to be achieved. The PDP should be specific and the outcomes must be, to some extent, measurable (Box 1.1).

How to best meet development needs will depend on a variety of factors. We all have preferred ways of learning; some may prefer individual reading, others group discussion or learning through experience. In addition, different objectives will be best achieved in different ways; attending a lecture might help to meet an objective of understanding the evidence base of pharmacological treatments, but would be unlikely to offer a doctor much if their objective was to improve their communication skills, in which case observation and practice with a respected colleague are more likely to be effective. The Academy of Medical Royal Colleges (2012) has created a useful template to help doctors structure their reflections when considering how new information relates to current practice and whether further actions are required (Fig. 1.1). Use of this template is encouraged by the Royal College of Psychiatrists (2015). There are many alternative approaches that can be adjusted as needed, but all tend to cover the same areas: what the activity was, what the learning was and how it will change practice. See Box 1.2 for examples (taken from Borton 1970). Such notes can be used in peer-group discussions, to demonstrate value and justify the allocation of CPD credits, and within the appraisal process, to demonstrate ongoing personal development and quality improvement.

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**Box 1.1 How to develop a good PDP**

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<td>1.</td>
<td>Gather information about the full scope of your practice (e.g., multi-source feedback, clinical activity, complaints and compliments, incident reports)</td>
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<td>2.</td>
<td>Make time to reflect on what the information says about your practice – what should you aim to improve?</td>
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<td>3.</td>
<td>Discuss it in a supportive and formative environment with others (e.g., a CPD peer group)</td>
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<td>4.</td>
<td>Agree specific objectives – SMART objectives are good:</td>
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<td>• Specific</td>
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1 Improving Patient Care through Continuing Professional Development

Title and description of activity

18/09/14: CPD Online Module — The Pharmacological Treatment of Resistant Depression: An Overview

What was the learning need or objective that was addressed?

CPD peer group agreed on an objective to better understand the evidence base behind different pharmacological interventions for treatment-resistant depression, as I had reflected that I had less confidence in poly-pharmacological interventions in this field than other peers.

The modules set out a series of steps to take to assess and then consider options at various stages of ‘treatment resistance’. Some evidence was presented in the form of meta-analysis. It was useful to be reminded of the importance of thoroughly assessing past treatments, response, other symptoms (e.g. psychotic or bipolar spectrum), before making any decisions about treatment options.

Potential adverse interactions were usefully summarised. The potential benefits of drugs I rarely use (e.g. MAOIs) were discussed and I need to consider my confidence in prescribing these. Although other interventions (e.g. ECT and CBT) were briefly discussed I would need to consider how, in practice, these would be used alongside changes to medication.

In terms of involving the patient in the decision making process more understanding of potential side effects would be needed.

What was the outcome of the activity?

Key learning points:
1. The importance of key areas to remember to include in the initial assessment — bipolar, psychotic symptoms — was emphasised.
2. I have learned a useful stepped model to consider and manage resistant/depression.
3. I have a good overview of the evidence base for augmentation therapies.

Changes to practice:
- In future my assessment will include specific areas for exploration.

Practice reinforced:
- Augmentation of antidepressant medication with other antidepressants or atypical antipsychotics is safe and effective.
- Caution when using antidepressants for people with bipolar spectrum disorders and consider non-antidepressant options.

Further learning needs

1. Understand the effectiveness of ECT, particularly earlier on in the process of treatment.
2. Revise prescribing and side effects of MAOIs. How will this activity improve patient care or safety?

Number of CPD hours claimed

1 h (agreed by peer group)

Fig. 1.1 Example of a reflective note using the Academy of Medical Royal Colleges (2012) template.
Box 1.2 Borton's model of reflection

What?
Describe the event. Consider:
• What happened?
• What was the response?
• Who was involved?

So what?
Think about the impact and meaning of the event. Reflect on the event. Consider:
• What happened as a result?
• How did this affect me?
• Why is this important?

Now what?
What are the consequences for you and others? What are you going to do as a result? Consider:
• What would you want to do differently?
• What needs to change?
• How are you going to achieve change?

Klob's learning cycle