CHAPTER 1

# Psychiatric training: the next steps

Dinesh Bhugra

Psychiatry is one of the key medical specialties, and has close relationships with non-medical mental health disciplines, with biology and with primary care medicine. Psychiatry has to demonstrate its effectiveness in dealing with mental illness and distress, and the role of the psychiatrist has to include educating the public, other physicians and legislators as well as employers. Psychiatry has to rise above the 'psychobabble' of pop psychology. The role of psychiatrists has changed dramatically in the past 50 years or so as the services have evolved and changed.

In the 1950s psychological therapies, biological pharmacological innovations and social psychiatry influenced the way psychiatry was practised. In the 1960s, specific neurotransmitter hypotheses led to an expansion in biomedical clinical investigation in psychiatry. In the 1970s and 1980s, although newer forms of psychotherapy emerged, the challenges to service development led to closure of mental hospitals and a shift towards community-based services, with community mental health teams as the focus for service delivery. In the 1990s the introduction of sub-specialisation based upon employer-/government-led initiatives, such as home treatment, continuing care and crisis resolution, held sway.

Various aspects of being a good psychiatrist include psychological mindedness (understanding the patient's and the trainee's subjective responses; objective approach to behaviour; ability to make contact with psychiatric patients; understanding of signs, symptoms and syndromes; ability to conduct and organise investigations and treatment methods using physical, psychological and social approaches; and an understanding of the self; Walton, 1986). These characteristics remain important for the psychiatrist after more than two decades.

*Good Psychiatric Practice* (Royal College of Psychiatrists, 2004) lists attributes of a good psychiatrist in the areas shown in Box 1.1. The core attributes of a good psychiatrist listed in *Good Psychiatric Practice* are given in Box 1.2. It is clear that there is a tremendous area of overlap in qualities of an individual psychiatrist as well as the characteristics of a service that will be acceptable to the patients and their carers.

**Box 1.1** *Good Psychiatric Practice* lists attributes of a good psychiatrist in these areas (Royal College of Psychiatrists, 2004)

- Trusting relationship
- Good clinical care
- Consent to treatment
- Note-keeping and inter-agency/inter-professional communication
- Confidentiality
- Availability and emergency care
- Working as a member of a team
- Referring patients
- Clinical governance
- Teaching and training
- Research
- Being a good employee and employer

The consultant of the future will have to have a range of competencies in clinical care, management, teaching, and research. The essential roles and key competencies are given in Box 1.3 and the attributes of a good consultant psychiatrist are shown in Box 1.4 .

Therefore, the training of psychiatrists will have to take on board a number of factors, including peer group-based learning, learning across disciplines and teams, and continuing professional development (CPD).

Certain driving forces within the profession have challenged our assumptions of training. These include continuing rapid expansion in our

**Box 1.2** Core attributes of a good psychiatrist (Royal College of Psychiatrists, 2004)

- Clinical competence
- Being a good communicator and listener
- Being sensitive to gender, ethnicity and culture
- Commitment to equality and working with diversity
- Having a basic understanding of group dynamics
- Being able to facilitate a team
- Ability to be decisive
- Ability to appraise staff
- Basic understanding of operational management
- Understanding and acknowledging the role and status of vulnerable patients
- Bringing empathy, encouragement and hope to patients and carers
- Critical self-awareness of emotional responses to clinical situations
- Being aware of potentially destructive influence in power relationship
- Acknowledging situations where there is potential for bullying

**Box 1.3** Essential roles and key competencies of a psychiatrist

*Medical expert*
- Demonstrate diagnostic and therapeutic skills for ethical and effective patient care: precise clinical history-taking, physical examination, investigation
- Apply relevant information and therapeutic options to clinical practice
- Demonstrate medical expertise in situations other than direct patient care
- Recognise personal limits of experience
- Demonstrate effective consultation skills with respect to patient care, education and legal opinions: present well-documented patient assessment

*Communicator*
- Establish therapeutic relationships with patients and their families
- Elicit and synthesise relevant information from patients, their families and communities: be aware of beliefs, age, gender, culture
- Listen effectively, foster understanding
- Discuss appropriate information with patients, their families and communities and other healthcare professionals

*Team player*
- Consult and liaise with other health professionals
- Recognise limits of personal competence
- Contribute effectively to multidisciplinary team activities (training, etc.)
- Aware of roles and expertise of other disciplines
- Integrate opinions of patients in decision-making

*Manager*
- Managing resources and time effectively to balance patient care, learning needs, outside activities and personal life
- Allocate finite healthcare and education resources effectively and work efficiently
- Utilise IT effectively to aid patient care

*Health advocate*
- Help promote health and prevent disability
- Identify social/cultural factors affecting health
- Recognise and respond to settings related to advocacy: populations at risk, policy awareness, development of policy

*Scholar/educator*
- Personal CPD strategy and learning needs and methods
- Be a critical appraiser of sources of medical information
- Educator: help others to define learning needs and development, provide feedback, adult learning

*Professional*
- Deliver highest quality care with integrity, honesty and compassion
- Appropriate personal and interpersonal behaviours: self-awareness
- Ethically acceptable/responsible: local laws

knowledge base and technology leading to changes in service delivery. Growth of sub-specialties and super-specialisation, changes in undergraduate education, arrival of increasing numbers of international medical graduates,

**Box 1.4** Attributes of a good consultant psychiatrist

*Medical knowledge*
- Up-to-date knowledge needed to evaluate and manage patients

*Clinical skills*
- Demonstrate proficiency in history-taking
- Effective physical examination
- Organise and evaluate investigations
- Lead and manage diagnostic studies
- Propose interventions based on individual formulation
- Demonstrate practice skills
- Show proficiency in technical skills

*Clinical judgement*
- Demonstrate clinical reasoning
- Make sound diagnostic and therapeutic decisions
- Understand the limits of knowledge
- Incorporate cost-awareness and risk–benefit analysis

*Interpersonal skills*
- Communicate and work effectively with patients, families, other members of the team and agencies

*Professional attitudes and behaviour*
- Accountability
- Accept responsibility
- Maintain comprehensive, timely and legible medical records
- Be available for consultation
- Seek improvement in quality of care provided
- Facilitating learning of patients, communities, students and other disciplines
- Lifelong learning
- Evaluate critically new medical and scientific information
- Self-awareness
- Humanistic qualities
- Demonstrate integrity and honesty
- Demonstrate compassion and empathy
- Respect for privacy and dignity
- Ethical practice

*Managerial skills*
- Effective and efficient working
- Utilise IT

*Health advocacy*
- Health promotion and prevention
- Advocacy for patients, families and communities

and structural changes within the National Health Service (NHS) and medical profession all indicate that training and delivery of training need to change.

Training is becoming outcome-based. For psychiatry it is crucial to determine what is good clinical care and what the working life of consultants

will look like in 10 years' time. The potential impact of documents such as *The Ten Essential Shared Capabilities* (Hope, 2004) cannot be overestimated. These shared capabilities are as follows.

- Working in partnership: developing and maintaining constructive working relationships with service users, carers, families, colleagues, lay people and wider community; working positively with any revisions created by conflicts of interest or aspiration that may arise between the partners in care.
- Respecting diversity: working in partnership with service users, carers, families and colleagues to provide care and interventions that not only make a positive difference but also do so in ways that respect and value diversity, including age, gender, race, culture, disability, spirituality and sexuality.
- Practising ethically: recognising the rights and aspirations of service users and their families, acknowledging power differentials and minimising them whenever possible; providing treatment and care that is accountable to service users and carers within the boundaries prescribed by national (professional), legal and local codes of ethical practice.
- Challenging inequality: addressing the causes and consequences of stigma, discrimination, social inequality and exclusion on service users, carers and mental health services; creating, developing or maintaining valued social roles for people in the communities they come from.
- Promoting recovery: working in partnership to provide care and treatment that enables service users and carers to tackle mental health problems with hope and optimism and to work towards a valued lifestyle within and beyond the limits of any mental health problems.
- Identifying people's needs and strengths: working in partnership to gather information to agree health and social care needs in the context of the preferred lifestyle and aspirations of service users, their families, carers and friends.
- Providing service user-centred care: negotiating achievable and meaningful goals, primarily from the perspective of the service users and their families, influencing and seeking the means to achieve these goals and clarifying the responsibilities of the people who will provide any help that is needed, including systematically evaluating outcomes and achievements.
- Making a difference: facilitating access to and delivering the best quality, evidence-based, values-based health and social care interventions to meet the needs and aspirations of service users and their families and carers.
- Promoting safety and positive risk-taking: empowering the person to decide the level of risk they are prepared to take with their health and safety. This includes working with the tension between promoting safety and positive risk-taking, including assessing and dealing with possible risks for service users, their families and the wider public.

- Personal development and learning: keeping up to date with changes in practice and participating in lifelong learning, personal and professional development for one's self and colleagues through supervision, appraisal and reflective practice.

## Developments in medical education

Contemporary developments in medical education have led to a situation where we have both the understanding and the opportunity to make significant improvements, especially at postgraduate level. This opportunity has largely developed from the reforms in undergraduate medical education outlined in *Tomorrow's Doctors* (General Medical Council, 1993). These were astonishingly slow in coming about. For example, a minute of the General Medical Council as long ago as 1869 warned about the dangers of an excessively burdensome curriculum, and Thomas Huxley, in an address in 1876, said that

'the burden we place on the medical student is far too heavy …. a system of medical education that is actually calculated to obstruct the acquisition of sound knowledge and to heavily favour the crammer and the grinder is a disgrace'.

Progress since the first of the modern *Tomorrow's Doctors* curricula came into operation in 1990 has been much more brisk. Today, every UK medical school has a modern undergraduate curriculum and the spotlight has now turned to postgraduate medical education.

Developments in postgraduate medical education have been initiated and shaped by various initiatives such as the recommendations for senior house officer training from the Conference of Postgraduate Medical Deans (Conference of Postgraduate Medical Deans, 1995), the Academy of Medical Royal Colleges (Academy of Medical Royal Colleges, 1996), the General Medical Council (General Medical Council, 1998), and the Department of Health (2002, 2003, 2004) with *Unfinished Business* and *Modernising Medical Careers*.

### *Postgraduate Medical Education and Training Board*

In 2003 the Postgraduate Medical Education and Training Board (PMETB) was established as the UK statutory body for standards in postgraduate medical education. Once established, PMETB became independent of government and set its own agenda and direction. Following the publication of *The NHS Plan* in 2000 (Department of Health, 2000), the stated aims for setting up PMETB included: cultural change (to 'modernise' the institutions of medicine and professional regulation of all the healthcare professions); resetting the constitutional checks and balances (an emphasis on professionally led regulation with public involvement); better connections between the institutions of postgraduate medical education and the needs of the NHS; more involvement of patients and the wider public;

bringing consistency and integration to the diverse collection of historical arrangements; and, perhaps most importantly, for one organisation to take on collective responsibility for postgraduate medical education and be accountable for ensuring that standards are met.

As PMETB itself acknowledges, its establishment was also influenced by negative impressions and experiences of the past which, although addressed by the relevant institutions, did not fully meet the ideals. Two additional factors were the perception that the Specialist Training Authority was a weak organisation, and that quality assurance of postgraduate medical education was not rigorous enough. Thus, the aim to bring about transparency and consistency to quality assurance functions led to the establishment of PMETB. Changes in the medical workforce, service provisions and patients' expectations were further triggers for the change. Modernising Medical Careers (MMC, see below) has set both short-term and long-term challenges for PMETB. Other factors that influenced the establishment of PMETB include international recruitment, a wish for a closer fit between the status and job titles of doctors and the work they do for the NHS, discrepancy in different regions of the UK, reforms in medical education and standard setting.

PMETB principles and guidance are set to shape a wide range of improvements under a new legislative framework. The key functions of PMETB are to deliver its stated and statutory functions, and to meet the needs of patients, doctors and the service through curriculum design, delivery, assessment and quality assurance in relation to the evidence base. The stated criteria for the success of PMETB are given in Box 1.5.

The PMETB came into force on 30 September 2005. The following priorities were set for its first year of operation:

- develop funding streams
- complete preparation to take on its role as the competent authority
- establish financial and contractual arrangements
- operate the first year of its certification processes efficiently and without delays
- deal with expected front load of applications under article 14
- operate first year of quality assurance arrangements
- play its full part in the quality assurance of the first foundation programmes
- further develop its standards for postgraduate medical education and communicate them effectively.

The PMETB is responsible for approving the curricula for each specialty. It defines curriculum as a statement of the intended aims and objectives, content, experiences, outcomes and processes of an educational programme, including:

- a description of the training structure (entry requirements, length and organisation of the programme, including its flexibility and assessment system)

**Box 1.5** Stated criteria for the success of PMETB

- Evidence that standards for medical education are informed by the needs of patients
- Quality assurance arrangements that:
  - are consistent
  - involve structured evidence-based decisions
  - are proportionate and harmonised with other quality assurance arrangements
  - are transparent
  - are perceived as relevant to the needs of the service
  - involve the wider public
  - make a difference and are seen to do so
  - command the confidence of the NHS and other UK institutions
  - are highly regarded internationally
- Certification arrangements that:
  - are consistent and fair
  - involve structured evidence-based decisions
  - have a credible and sound approach towards doctors trained overseas
  - command the confidence of the NHS and other UK institutions
- Governance arrangements that match best practice and Board activity that is open to public and professional scrutiny
- An organisation fit for purpose, well run and recognisable as a learning organisation
- Efficient and financially sound, with genuine involvement of the wider public, trainee doctors and the NHS
- Real and perceived independence from the government
- International repute

- a description of expected methods of learning, teaching, feedback and supervision.

The curriculum should cover both generic professional and specialty-specific areas. The syllabic content of the curriculum should be stated in terms of what knowledge, skills, attitudes and expertise the learner will achieve. The standards for the curriculum are available from PMETB.

## *Modernising Medical Careers*

*Modernising Medical Careers* (Department of Health, 2004) built upon the educational aims set out in the document *Unfinished Business* (Department of Health, 2002, 2003). The former's underlying educational principles are:

- outcome-based educational process
- defined competence
- assessment of competence
- lifelong professional development.

After graduating from medical school doctors now undertake an integrated 2-year foundation programme followed by specialist training with a unified training grade and a 6-year rotation within which the current training plan will broadly remain in place.

## Foundation programme

The aims of the foundation programme are to develop generic skills, competencies and attitudes to ensure professional conduct that will reflect good medical practice. The experience of working in psychiatry in either the first or second year of the foundation programme will allow trainees to 'sample' the specialty and will improve and encourage recruitment. This will be an induction to what is currently basic specialist training (but may well change into specialist unified training). The foundation programme aims to help trainees develop competencies that will enable them to progress further in their chosen fields. Modernising Medical Careers recommends clear entry criteria for foundation programme training. The application procedure is under review (see http://www.mmc.nhs.uk/pages/home for latest details).

In foundation year 2 (FY2) the trainee will be expected to do at least three placements of 4 months each. Psychiatry offers unique training opportunities for working with multidisciplinary teams, culturally appropriate and ethical services. Essential elements of the programme as indicated in *Good Medical Practice* (General Medical Council, 2001) are professional competence, good relationships with patients and colleagues, and ethical clinical practice. The principles of multidisciplinary working and knowledge of the roles of individual team members and the basic provisions within mental health legislation are all essential components of the curriculum agreed across different specialties, as are a number of competencies, such as communication skills. Patient-based learning encourages trainees to gain experience in multiple settings and gain an understanding of the impact of biological, social, psychological (as well as broader spiritual and anthropological) factors on the genesis and perpetuation of mental illness. By following the patients' journeys throughout their contact with psychiatric services from the presentation of acute illness, through investigations – physical, psychological or social – to reach a diagnosis and obtain a basic understanding of the management plan, the trainees can start to synthesise the information and develop skills and competencies. Personal attention, with supervision at both educational and clinical levels will encourage trainees further to develop their competencies.

Educational supervisors will provide continuity of supervision over the 1-year period irrespective of the clinical job the trainee is doing. The responsibilities of educational supervisors will include assessment, appraisal, mentoring, career guidance and evaluation of educational and training programmes. Supervision is a formal process that allows the trainee to grasp an academic perspective on questions arising from direct patient care.

Assessment of trainees in FY2 includes monitoring how the trainee manages to: examine a patient's mental state; work within a multidisciplinary team; arrange investigations; collate third-party information; and understand how management plans are reached and acted upon. The aims, objectives and outcomes of the psychiatry programme are given in Box 1.6.

Key features of the foundation programme are set out below.

- Doctors in the programme will take responsibility for their own learning and take advantage of all the learning opportunities presented within the day-to-day work of each attachment.
- Competence and performance will be objectively assessed throughout the programme.
- The programme will instil in doctors the need for continuous professional development and lifelong learning.
- Successful completion of the first year of the foundation programme will fulfil the criteria for full registration with the GMC.
- Successful completion of the second year of the foundation programme will indicate that the doctor is professionally accountable for patient safety and ready to start a programme of further specialist training.

The foundation programme will enable medical graduates to:

- consolidate and develop their clinical skills, particularly with respect to acute medicine, enabling them to reliably identify and manage patients in whatever setting they present
- embed modern professional attitudes and behaviours in every aspect of clinical practice

**Box 1.6** Aims, objectives and outcomes of the foundation programme in psychiatry

*Aims*
- To produce doctors with the knowledge and competency to treat common psychiatric conditions

*Objectives*
- To identify mechanisms underlying an exemplar condition, e.g. depression
- To develop skills in history-taking and mental state examination for an exemplar condition, e.g. depression

*Intended learning outcomes*
- To attain and utilise knowledge and skills required to treat common psychiatric conditions
- To identify and summarise mechanisms underlying an exemplar condition, e.g. depression
- To acquire and demonstrate skills in history-taking and mental state examination for an exemplar condition, e.g. depression

- demonstrate the acquisition of competence in these areas through a reliable and robust system of assessment
- explore a range of career opportunities in different settings and areas of medicine.

The curriculum puts quality of care and patient safety at the centre of clinical practice. The learning environment for the foundation programme will be:

- trainee-centred
- competency-assessed
- service-based
- quality-assured
- flexible
- coached
- structured and streamlined.

All foundation training will be delivered within a foundation training programme led by a foundation training programme director/tutor. There will be three types of appointments into foundation training programmes:

- 2-year appointment to encompass F1 and F2 training
- 1-year appointment to F1 (first year of foundation training)
- 1-year appointment to F2 (second year of foundation training).

***Postgraduate deaneries***

The postgraduate deaneries have operational responsibility and accountability for ensuring that the foundation programme is delivered to the national standards set by the GMC and the PMETB. The deaneries will need to ensure that there is an effective educational infrastructure to support the development of the foundation training programme by establishing foundation schools, which are responsible for the operational aspects of delivering the programme (see Fig. 1.1). This won't apply to all, as several deaneries have established Schools of Psychiatry and appointed Heads of these Schools in conjunction with the Royal College of Psychiatrists.

Foundation schools operate under the auspices of the postgraduate deans who will develop, in conjunction with the university and medical school/s in the deanery, the educational framework. In addition, close working with provider organisations will be essential to develop and maintain such supportive environments. Overall accountability for the quality of training delivered through the school will rest with the university and the postgraduate dean, with particular responsibility for the F1 year falling to the university.

Quality assurance for foundation training will be through a joint approach to be established by the GMC and the PMETB, which will quality assure the foundation training programme overseen by the deaneries. The deaneries will quality control the delivery of foundation training through the monitoring of educational contracts with NHS employers.

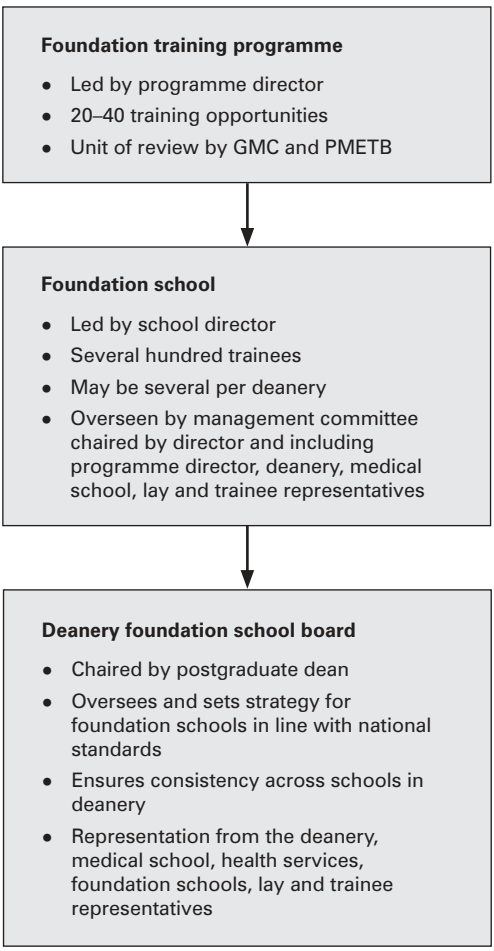


**Fig. 1.1** Proposed delivery of the foundation training programme. GMC, General Medical Council; PMETB, Postgraduate Medical Education and Training Board.

Foundation schools will support no more than 20–40 combined F1 and F2 training opportunities (posts) providing foundation training, and normally one programme director/tutor will look after 20-40 posts and the trainees in them.

Deaneries may establish a foundation school management committee or school board, comprising the postgraduate deans, the directors of postgraduate general practice education, the dean of each medical school linked to a foundation school, the directors of each of the foundation schools, an NHS chief executive from each school, a lay representative, a trainee representative from each school, and others as deemed necessary

locally. At each level sufficient administrative and infrastructure support must be available to allow training and education to progress smoothly.

Trainees will follow an individual foundation programme. It is possible for deaneries and training programme directors to look at the number of SHO posts and covert some into FY2 posts. As the unified training grade implies a columnar approach (with 5–10% attrition) rather than the current pyramid, it should be possible to 'shave off' some of the SHO numbers to convert them into FY2 posts; 33% of SHO posts in Scotland have been successfully converted to FY2 posts.

**Specialist training**

A unified training grade has been recommended as the way forward. The trainees for specialist training are being appointed for a 6-year rotation within which the current training plan will broadly remain in place (Fig. 1.2). The current three basic specialist training years will remain the same and the assessments for MRCPsych examinations will remain roughly at the same times.

The MRCPsych part I examination will be taken after at least 1 year of training and part II after 20 or 36 months. As PMETB is approving training schemes, the eligibility criteria for the examinations will have to change. The Royal College of Psychiatrists is exploring the possibility of offering MRCPsych examinations overseas. Further information is available from the College website (http://www.rcpsych.ac.uk/training.aspx).

The unified training grade will be called specialist training (StR) and the years of specialist training will be ST1–ST6. The first year of specialist training will have 6 months of general adult psychiatry and 6 months of old age psychiatry or rehabilitation psychiatry. In the first 3 years, 6 months of developmental psychiatry will be mandatory. From day one, specialist trainees will take on patients for 'long-term' psychotherapy and over the 6-year period they will be expected to treat at least two patients using 'long-term' psychotherapy, others using cognitive–behavioural therapy and two using behaviour therapy. They will be expected to be 'selected' into sub-specialty training at the end of 3 years. The entry criteria for specialty selection need to be confirmed but will be influenced by the criteria established by PMETB.

## *European Working Time Directive*

The European Working Time Directive (EWTD) is the health and safety legislation adopted by the European Commission in May 2000. From August 2004 the NHS has been required to ensure that their employment of junior doctors adheres to EWTD legislation. The key points of the directive are that workers must have an 11-hour rest in every 24 hours – or a minimum 20 min break when their shift exceeds 6 hours – a minimum 24-hour rest in every 7 days, a minimum 48-hour rest in every 14 days, a minimum of 4 weeks' annual leave and a maximum of 8 hours work in every 24 hours for night workers.

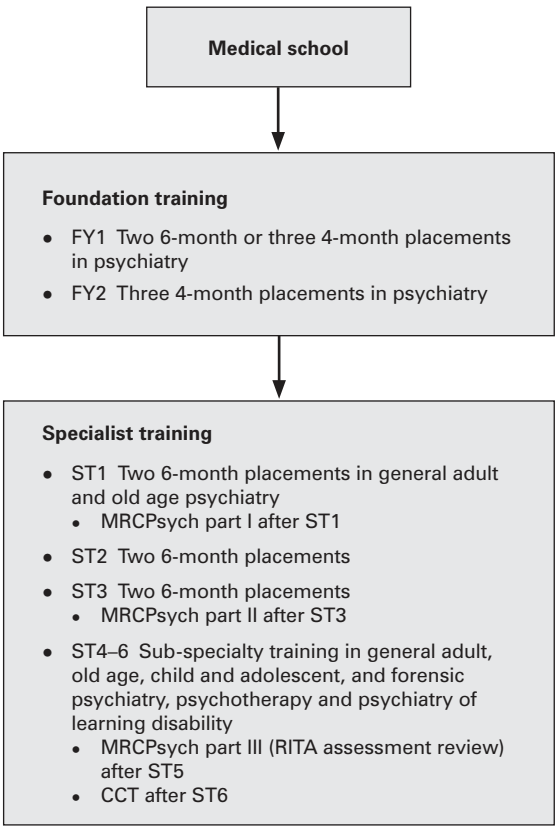


**Fig. 1.2** Proposed training for psychiatrists after leaving medical school. RITA, record of in-training assessment; CCT, certificate of completion of training.

In some deaneries, trainees are being offered 4-month placements although Tooke (2007) in his interim report recommends 6-month placements.

Changes in service delivery will influence education and training. In addition, continuity of care and experience of long-term care may become difficult to achieve. Other problems that may emerge as a result of implementation of the EWTD include difficulties with regular educational supervision, with the likelihood of it changing its format. In addition to the EWTD, the subdivision of adult community psychiatry into home treatment, assertive outreach, crisis resolution and other teams will make delivery of educational supervision much more difficult and irregular. Sessions devoted to sub-specialty training will also have to undergo a change. The EWTD is also likely to affect acting up or acting down, in that emergency or routine

cover may need to be provided by a team of doctors with varying grades and levels of competence, rather than doctors simply performing a set of preordained duties.

The introduction of new shift patterns will radically alter the opportunities for teaching and learning through face-to-face contact. The focus in training has to shift to self-directed learning where the trainees take on the responsibility for their training and optimisation of the limited contact between trainers and trainees. The trainee logbook will become an important component of overall assessment. The teaching will have three components: patient-based (ward rounds, topic-based bedside teaching, outpatient-based, case conferences, psychotherapy, audit and clinical governance); classroom-based (web-based learning, didactic teaching, journal clubs); and learner-based (educational supervision directly or indirectly using web-based methods, formal and informal study).

Patient-based learning activity will be systematic with emphasis on patient problem-based learning. The learning will not necessarily be apprenticeship, and formal documentation such as a logbook or portfolio of competencies achieved will be the core of future assessments. Individual patient encounters, on wards or in out-patient departments, will be assessed using direct observation and video links with reflective analysis as well as problem-based learning.

Classroom-based activities of the kind currently used in MRCPsych courses will change. The EWTD means trainees will miss many classroom-based teaching sessions because of rest or work requirements. Although an arbitrary figure of 75–80% attendance has been used by many courses to date, this is likely to decrease under the EWTD. The trainees will have to build upon their experience and record it individually or in a group. They will complete their logbook against their agreed learning plan and the logbook will be assessed and monitored at trainee appraisals and by educational supervisors. The Royal College of Psychiatrists may choose to randomly audit these logbooks.

Learner-based training will be self-directed and the trainees will keep their logbooks along with web-based learning. They may choose to record details of supervision, papers read, journals and book reports, distance learning, etc.

Educational supervision may need to follow the foundation year 2 (FY2) structure where one educational supervisor is responsible for a number of trainees and a distinction is made between clinical and educational supervisors. In addition, the educational supervisors will have dedicated programmed activity in their job plan agreed by the employing trust. It is expected that each educational supervisor will have between 8 and 10 trainees. The educational supervisor will not necessarily supervise all of them at the same time but will facilitate and provide supervision for a longer period. The clinical supervisor will continue to provide supervision in clinical settings. Educational supervision may occur through electronic means using email, web cam, video conferencing, etc.

Clinical experiences in sub-specialty training such as psychotherapy will have to be planned well in advance, and the trainees have to demonstrate in workplace-based assessment that they have acquired competencies as required and at the right stage during their training.

## Workplace-based assessments

Many of the anticipated improvements in psychiatric training will be in the area of assessment, and the positive influence of PMETB on the curriculum in general and assessment in particular are already becoming evident. For example, all assessment systems must satisfy PMETB's *Principles for an Assessment System for Postgraduate Medical Training* (PMETB, 2004). Furthermore, the future design of assessment systems should ensure that the assessments are fit for purpose, and part of a coherent assessment strategy that also fulfils the requirements of *Good Medical Practice* (General Medical Council, 2001), the NHS appraisal for doctors in training framework (http://www.dh.gov.uk) and revalidation. An important aspect of 'fit for purpose' is to avoid unnecessary assessments – those that either duplicate other assessments or that are made too frequently to be of value.

The PMETB proposes an overarching assessment strategy consisting of workplace-based assessment and examinations of knowledge and clinical skills. It is recommended that this assessment strategy relates to the entire training period and that this is mapped to a blueprint. The balance between workplace-based assessment and formal examinations, and the methods used in each, is likely to vary from specialty to specialty and to alter over time.

A recent trend in medical education is to soften the distinction between formative and summative assessment. Formative assessment is typically undertaken to provide feedback to the doctor in training and their educational supervisor about progress and potential difficulties, but without contributing in any way to pass/fail decisions. Summative assessment, on the other hand, is traditionally concerned only with formal testing of attainment and forms the very basis of pass/fail decisions. Keeping the two quite separate has been useful in the past to both curriculum and test developers. The distinction still exists today, but is much softer and should always be in the trainee's favour. This is because the emphasis is moving rapidly away from gaining a certain number of marks in high-stakes examinations and far more towards gathering evidence of clinical competence and appropriate professional behaviour and attitudes. Much of this evidence cannot be captured in the kind of formal examinations that have traditionally been the primary focus in postgraduate training. It is demonstrated, day in, day out, in the workplace and is seen by educational supervisors, other team members, fellow healthcare workers, patients and their relatives and carers. Since it is both demonstrated and observed in the workplace, then it stands to reason that the workplace is where the evidence can be gathered. This is

why workplace-based assessment will become increasingly important over the next few years.

From an educational perspective, there is good sense in developing workplace-based assessments given the contemporary view that assessment should be an integral part of educational planning in which teaching, learning and assessment are closely integrated. Furthermore, workplace-based assessment has the advantage of offering high validity, because of the authenticity of assessing performance in the workplace rather than by simulation or in the examination hall. For example, Jolly *et al* (1997: p. 232) noted that

> 'to achieve valid assessments of clinical competence it is plain that more use will have to be made of "real life" events and practice'.

We have long known that assessment is a potent driver for learning (Entwhistle, 1981; Newble & Jaeger, 1983; Stillman & Swanson, 1987; van der Vleuten *et al*, 1997). Indeed, 'assessment of attainment can prove to be the most powerful factor in the entire curriculum' (Holsgrove, 1997*a*: p. 181) and it commands a place of its own in consequential validity (e.g. Holsgrove, 1997*b*: p. 185), which is the aspect of validity that is concerned with the effect that assessment has on what and how students learn. It is therefore imperative that assessment focuses on what is considered important rather than what appears to be easiest to assess. Not only will this support appropriate learning but it is also essential given the increasing requirement for public reassurance that doctors are safe and competent. Therefore, in order to seek assurance that doctors are performing well, or to identify under-performing doctors, the focus of their professional development and its assessment must be based upon what they actually do in the workplace.

The assessments in the foundation programme will include multi-source feedback (including the Mini-Peer Assessment Tool), the Mini-Clinical Evaluation Exercise (mini-CEX), direct observation of procedural skills (DOPS) and case-based discussion. Trainees will keep a foundation learning portfolio, which will include personal development plans, self-appraisal tools, records of structured meetings and review forms. The reviews will occur at the mid-point and end of placement. An educational agreement will be signed between the trainee and the educational supervisor. The trainees will monitor their own reflective practice by evaluating learning experiences and untoward incidents. The trainees will also be required to provide information on their probity and health within the context of portfolio assessments.

Workplace-based assessments provide an excellent opportunity to ensure that teaching, learning and assessment are fully integrated and appropriate to the needs of the learner. They should ensure learning and professional development are monitored and supported by the systematic collection of evidence, with the assessment activity occurring mainly in the workplace. Procedures for triangulation of evidence and moderation of the summative

judgments made, along with other means for quality assurance, must be properly planned, robust, explicit and publicly available. The requirements of PMETB will inevitably lead to significant developments in practice, both in the workplace and in the College examinations.

## Postscript

Since this chapter was originally written in 2006, further developments have occurred. The selection process using the Medical Training Application Service (MTAS) had major problems that left nearly a quarter of applicants feeling suicidal (Lydall & Bhugra, 2007). Following this fiasco, an inquiry into MTAS was carried out and the government also established an independent inquiry chaired by Sir John Tooke, whose interim report *Aspiring to Excellence* has recently been published (Tooke, 2007). Among a total of 45 interim recommendations are the following: the decoupling of FY2 from FY1 and including it with families of specialties in core specialist training; the merger of PMETB into the GMC; an increase in the period of GP training to 5 years; a careful assessment of the role of the doctor; the linking of deaneries with local medical schools; harmonisation of FY1 with Year 5 in medical schools; making medical directors responsible for delivery of training; and establishing a Director of Training at the Department of Health. We wait for the government to announce which, if any, of these recommendations will be accepted and what the timescale will be for implementing them.

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