



education & training

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Bringing psychiatry training to the next generation: a Foundation Year 1 doctor's tale

The Foundation Programme is a 2-year programme in the UK which forms the bridge between medical school and specialist/general practice training. It provides trainees with a broad range of experiences enabling them to apply for specialty training at an earlier stage. J.K., consultant psychiatrist in old age psychiatry, tells us about the experiences of hosting a Foundation Year 1 (FY1) doctor for the first time and the first incumbent G.T. (FY1) adds his views.

Development of the post from a consultant's perspective

Training of medical staff has always been a core activity of Lancashire Care National Health Service (NHS) Foundation Trust. There have never been pre-registration house officers in psychiatry and we were delighted to be approached with the concept of developing an innovative FY1 post in elderly psychiatry. Although we knew of Foundation Year 2 (FY2) posts developed from more traditional senior house officer roles, the FY1 post was unique in that we had no mental health reference points to guide us in its establishment. Review of traditional roles of the pre-registration house officer helped us draw parallels between the training objectives of trainees in medicine or surgery and those in psychiatry. The Foundation Year curriculum inspired confidence that this training opportunity could meet those objectives.

The FY1 post was developed within a multidisciplinary team. Clinical responsibilities were confined to the in-patient unit but experience of how complex health and social service provision is delivered was encouraged throughout. Skills of history taking, physical examination, documenting, preparation for team meetings, arranging investigations, developing management plans and referring to others are not unique. Older adult mental health does, however, provide specialist expertise in the assessment of confusion, the management of challenging behaviour, informant history taking and other communication skills, risk assessment, assessment of capacity and best interest decisions. A valuable induction is provided for all trainees including mental state examination, risk



assessment, the Mental Health Act, personal safety and breakaway techniques.

Developing such a post has posed various challenges, such as ensuring the availability of senior supervision at all times, policies not permitting independent prescribing and mental health nurses lacking familiarity with FY1 competence. The time spent on supervision has been repaid by the contribution to continuity of care as senior trainees are drawn away from it with shift systems and training. The incorporation of a new trainee has facilitated the involvement of more senior trainees in training and the FY1's educational objectives inspired us to raise standards and perform in areas such as audit.

Our ambitions have been to provide an opportunity for nascent psychiatrists to experience the specialty before the Core Trainee choice and, more importantly, to instil recognition that a large proportion of all clinical care is for older adults with mental health disorder. Understanding this and grasping how to identify that disorder, conduct initial assessment and access services will serve our trainees and their patients well.

A trainee's perspective

As an undergraduate I was interested in psychiatry and was delighted to be accepted for this new psychiatry FY1 placement.



Foundation Year 1 and 2 trainees are assessed with direct observation of procedural skills, clinical evaluation exercise (mini-CEX), case-based discussion and multi-source feedback (mini-PAT). I had no problems completing mini-CEX and case-based discussion because of the weekly educational supervision sessions. I was encouraged to experience other services within a multidisciplinary team, hence the multisource feedback was truly multidisciplinary. I was able to appreciate what each discipline brings to care and when, why and how they are accessed. Regarding direct observation of procedural skills, only simple procedures could be undertaken, although the same standards were achieved in general regardless of complexity.

Achieving the overall 'generic' competency standards did not pose any problems, although 'acute care' competencies were challenging. For mental health problems, the senior house officer would take responsibility. For physical problems, I found there was the limitation in treating physical problems in the psychiatric setting. I felt that not having on-call commitments and the Trust guidelines not allowing independent prescribing was restricting; however, subsequent feedback from senior colleagues has shown that overall development has not suffered.

On reflection, I have enhanced my patient-centred approach by appreciating the circumstances of those with mental health problems. I have been able to discuss psychiatric referrals of variable quality and have been able to educate others where a mental health multidisciplinary team opinion might be of value, who in the multidisciplinary team can best provide this and what information adds to the quality of their response. I also appreciate why physical problems receive limited treatment in psychiatric settings. A growing number of doctors working in diverse specialties will increase understanding of how others work, leading to better working relationships and ultimately improving care.

The new training structure in the UK has received criticism, but my experiences have converted me to be its cautious welcomer. I await my application to psychiatry specialty training with interest.

Declaration of interest

None.

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What is it about dynamic psychotherapy?

The new Modernising Medical Careers agenda in the UK raises concerns about maintaining the standard of psychotherapy training (Mizen, 2007). In 1993 the Royal College of Psychiatrists made psychotherapy a mandatory rather than recommended work experience and there is now a competency portfolio outlining requirements for trainees. However, startling data have been revealed recently, showing that 91% of senior house officers did not meet the requirements of the Member of the Royal College of Psychiatrists (MRCPsych) exam regarding psychotherapy training and 23% were not even aware of them (Agarwal *et al*, 2007). The quality and variability of psychotherapy experience in training have been surveyed in several papers (Podlesjka & Stern 2003; Carley & Mitchison 2006; Pretorius & Goldbeck 2006), and some solutions to practical problems with its provision have been proposed, for example, consultation from a consultant psychotherapist, utilising feedback from trainees, and focusing on practicalities and logistics at a local level (Wildgoose *et al*, 2002; Mitchison 2007). However, little has been said about trainees' own experiences of undertaking supervised practice in psychodynamic psychotherapy. This paper discusses trainees' outlook on psychotherapy training schemes.

Case study 1

'After sitting in a supervision group over the recommended 6 months, listening and trying to sound like I understood, asking questions, and more listening, I eventually plucked up the courage to find the waiting list, read a few assessments and pick a name. We discussed it in supervision. I started. The first session was easy; meeting, greeting, talking about the boundaries, the rules and expectations. I talked, [the patient] talked, it was great, and we both left feeling positive and empowered. The next session it was [the patient] and me in the room. I imagine we were both thinking, 'What am I doing here?' I wrote everything down afterwards. I wanted to get it right. The session after that [the patient] did not attend. What followed over an 18-month period was a growth, an intense emotionally charged experience of being in that room, sitting on my hands, biting my lips, controlling my face, wondering if I was being too 'cognitive'? Sometimes feeling completely rubbish and sometimes feeling like the best therapist that ever lived. I had not previously been so entangled in a patient's internal world.'

Unlearning and relearning

The wealth of literature is testament to the general feeling that psychotherapy is different from the rest of