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Modernising psychiatric education

Postgraduate medical education has recently been the subject of major and fundamental review. The four UK Health Departments have set out the underpinning principles in *Modernising Medical Careers* (Department of Health, 2003), which sees the adoption of a number of trends that have emerged in medical education. One such trend is an emphasis on learning and the development of skills, including continuing professional development, with a move away from the apprenticeship model towards more structured and systematic training. This also means that structured training programmes that have defined curricula and show clear quality assurance processes will become the norm. The aim is to have a flexible, trainee-centred approach within which individuals can develop at their own pace and take increasing responsibility for their own training in a variety of clinical settings.

Training is therefore becoming increasingly outcome-based. Thus, for psychiatry, consideration of what constitutes 'good clinical care' and the working life of the consultant are fundamental. Trainees in psychiatry must acquire a detailed understanding and knowledge of the signs and symptoms of common psychiatric disorders, with an understanding of their epidemiology and aetiology, familiarity with their presentation and awareness of referral pathways, including those for emergencies. Such knowledge must include an awareness of the principles of – and competence in – clinical assessment, prognosis and common therapeutic strategies. Trainees must have a clear understanding of the principles of multiprofessional team working and the role of individual members within multiprofessional teams; they should also be familiar with the legislation applied in mental health work, they should reflect on the ethical dilemmas presented and demonstrate an understanding of broad ethical issues.

Some of these requirements are beyond dispute, but others have been the subject of considerable debate. The current position is helpfully outlined in *Guidance on New Ways of Working for Psychiatrists in a Multi-disciplinary and Multi-agency Context* (Department of Health, 2004). This highlights the need to develop not only knowledge and expertise but also skills for lifelong learning (continuing professional development) and team working with fellow professionals, patients and carers and attitudes in the form of a value-driven ethical basis for practice.

This training is taking place in services that are themselves the subject of considerable change following the implementation of legislation such as the European Working Time Directive and policy initiatives such as the Mental Health National Service Framework and the National Health Service (NHS) National Plan.

Foundation Programme

The changed training process will be based on the creation of a new programme, the Foundation Programme. Understanding that a new programme for all doctors is envisaged is fundamental to the achievement of the aspirations of *Unfinished Business – Proposals for the Reform of the Senior House Officer Grade* (Department of Health, 2002) and *Modernising Medical Careers* (Department of Health, 2003). The details are discussed elsewhere (Brown & Bhugra, 2005).

The educational aims of the 2-year programme will be to develop generic skills, competencies and attitudes to ensure professional conduct that will reflect 'good medical practice', as defined by the General Medical Council (1998). These will include enhanced clinical skills (including assessment and management of emergencies), effective relationships with patients, high standards in clinical governance and patient safety, the effective use of evidence and data, communication, team working, multiprofessional practice, time management and decision-making, and an effective understanding of the different settings in which medicine is practised.

The Foundation Programme will not be simply an opportunity to commence specialty training in a different format. Careers advice will provide a vital part of the overall programme content.

Specialist training

Trainees will graduate from the Foundation Programme with an eligibility to commence specialist training. In common with all aspects of training, specialist training will come under the auspices of the Postgraduate Medical Education and Training Board, which is due to come on stream in September 2005. The principles of training are that it should be trainee-centred, competency-assessed,

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service-based, quality-assured, flexible, coached, structured and streamlined.

It is proposed that specialist training be delivered in a single unified grade. The plan may incorporate a limited range of options for clinical attachments. The outcome of this phase of training will be the achievement of a Certificate of Completed Training. It is not clear as yet whether psychiatry will have a single certificate or more than one. Trainees will develop a range of competencies appropriate to their future work and roles as independent practitioner (NHS consultant or equivalent). Work has commenced on the curriculum but the emphasis will continue to be on the achievement of excellence rather than mere proficiency, and capability rather than simply competence.

Assessment

The changes to the schedule of assessment are fundamental to the changes proposed. Assessment methods will be varied. The objectives will be to assess across the domains of learning. Thus, for example, although assessments of knowledge will continue, they may be taken when trainees feel they are ready rather than at a time predetermined by an examination or training schedule. There will be a particular emphasis on performance, which is putting competence into action. Therefore in-training or work-based assessments will come to the fore.

The underlying principles for such an approach require close and careful consideration and debate. The competence-based curriculum will determine the content of the assessments. For this purpose, 'competencies' means the abilities that are central to the practice of medicine and psychiatry. Thus assessments must determine not only a range of knowledge, skills and attitudes but also how they are integrated into practice. Any assessment given must test professional judgement.

The assessments will follow a competency-based curriculum delivered in modules. These modules will each be worth 20 academic credits amounting to 200 h of combined didactic teaching, self-directed learning, supervision and clinical practice and experience. It is envisaged that there will be four level I modules (equivalent to the MRCPsych Part I examination) and five level II modules (equivalent to MRCPsych Part II). The precise modular structure for higher specialist training is being planned. It is expected that these changes will be in place by autumn 2008. Multiple choice question papers administered at the convenience of candidates will be used to assess the theoretical modules once the modules have been verified as completed. It is expected that these papers will be administered electronically at secure computer centres. The clinical modules will continue to be assessed by a combination of methods. These will include objective structured clinical examination, chart stimulated recall oral examination, global rating of live performance and structured patient management problems. Both clinical competence (behaviour in an artificial setting) and clinical performance (behaviour in the workplace) will be assessed.

It is envisaged that candidates will have completed the level I modules within the first 12 months of post-graduate training. All the level I theoretical modules and assessments (three in all) will stand alone. These modules will have to be completed before the candidate can proceed to the level 1 clinical module.

It is anticipated that candidates will complete the level II modules after a further 30–36 months of post-graduate training. The four theoretical modules will stand alone and must be completed before the candidate can proceed to the level II clinical module.

The level III modules will be drawn together in a portfolio which includes measures of process and outcome. Process assessments such as dialogue around learning diaries and monitoring of data will be merged with outcome data such as multiple performance observation and assessment, modified essay questions, written (project) reports, and oral presentations and posters.

Post-Certificate training

Following attainment of a Certificate of Completed Training an individual will be eligible for a general consultant post. Every doctor will enter a programme of continuing professional development. A range of learning materials and assessments will be developed that will enable individuals to fulfil personal and professional obligations. For many, a specific programme will be commenced leading to an endorsement or accreditation in one of the sub-specialties. Learning will occur while the doctor is working as a consultant. For example, a doctor who has gained a Certificate in general psychiatry might proceed to gain an 'endorsement' in, say, forensic psychiatry, which would entail clinical and academic learning before recognition by completing a number of level IV modules. This will mean a number of relational changes. Employing trusts will have to dedicate time and resources, and it is therefore likely that individuals will develop towards a particular job or service need. Those responsible for the delivery and assessment of teaching and learning may require new skills and need to develop new relationships with their 'peers'.

The way forward?

One way of meeting the needs would be to create 'training schools' in psychiatry. Two types of school could be considered: pre-Certificate or basic, and post-Certificate or lifelong learning.

Basic training school

A basic (pre-Certificate) training school would provide training for doctors entering from Foundation Programmes and take them through to attainment of their Certificate of Completed Training. These schools would be geared to deliver 'run-through' training. Their educational infrastructure would provide a full range of

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clinical posts, learning opportunities, academic opportunities and exposure to evidence-based practice for all trainees. Training school staff would need a number of attributes, including energy, enthusiasm, the ability to deal with administrative tasks in an efficient, timely fashion and possession of above-average communication skills, plus professional attributes to command the respect and support of peers. Their managerial knowledge and skills should include the ability to manage complexity, understand and practise equality of opportunity and value diversity; educational qualities should include knowledge of contemporary values and principles of medical education in the NHS, specifically in relation to the specialty, plus commitment to development of personal knowledge and skills as an educator through the dedication of a suitable proportion of their continuing professional development to this purpose.

Their background is likely to contain experience as lead educator (e.g. tutor or training programme director) and as medical manager (e.g. clinical director). The time/reward schedule would depend on the size of the scheme, but approximately four to six programmed activities would be allocated for schools with around 100 plus trainees and would include undertaking regular appointment panels, assessments of competence, post-evaluation, record of in-training assessments (RITAs), etc.

In addition there may be lead educators or associate directors whose role will vary, with responsibility for taught courses, assessment, mentorship and other roles. Their background will probably be as local trust or unit tutors. Larger schemes might appoint year coordinators with responsibility for the supervision of rotations, mentorship/support for trainees and provision of career advice. Schools would require an administrator to provide management of the school itself, including financial management, employment of trainees, arrangement of the RITA process, and administration of study leave budget and quality assurance.

Lifelong learning school

The post-Certificate, lifelong learning school would work with individuals and their employers to deliver targeted individual training programmes aimed at taking doctors from 'generalist' to 'specialist' (*Modernising Medical Careers*, Department of Health, 2003). These schools would be required to work closely with employers (trusts) and workforce development confederations. In order to develop sufficient infrastructure and expertise they might need to be larger (in geographic terms) than the basic schools.

Conclusions

There is little doubt that radical reform of the current postgraduate medical training system is under way. This paper is intended both to reflect the current position and thinking, and to provide some guidance, but more importantly to stimulate thought and debate about what structures, personnel and development programmes are required for the future world of medical education. Whatever conclusions are enacted there must be adequate planning and fair warning to trainers and trainees about the intended changes; and these changes must be seen to be led and implemented by the College.

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