MCQ answers

1	2	3	4	5
a F	a F	a F	a F	a T
b T	b F	b T	b T	b T
c F	c F	c T	c T	c F
d T	d T	d T	d T	d F
e T	e F	e T	e T	e T

What needs balancing?

Invited commentary on: A balancing act

Dinesh Bhugra

Curriculum is not the same as syllabus. The latter is a statement of topics to be studied in a specific course. The former ranges from a statement of purpose, aims and contents (the paper curriculum) to how these are applied in practice, what learners do and the behaviours, knowledge and performances that they see as important. The Postgraduate Medical Education and Training Board (PMETB) 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 flexibilities, and assessment system],
> - a description of expected methods of learning, teaching, feedback and supervision.
>
> The curriculum should cover both generic professional and specialty specific areas'
>
> (Postgraduate Medical Education and Training Board, 2005: p. 2).

Grant *et al* (2005) clearly define standards for a medical curriculum, including its rationale, content of learning, model of learning, learning experiences, supervision, revision, feedback, managing its implementation and dealing with diversity and equality. The Royal College of Psychiatrists is one of the most responsive medical Royal Colleges in rising to the challenge of producing a new curriculum, even though it has been tremendously time-consuming and has taken us over a year to develop.

The place of community psychiatry

Community psychiatry is now part of the bedrock of psychiatry. It has developed over the past quarter of a century as asylums have closed and services have moved nearer to where patients and their carers live. By definition, it is psychiatry practised in the community, often in the context of a community mental health centre with community mental health teams (CMHTs) who have access to in-patient services (Ayd, 1995). Ayd sees community psychiatry as more stressful and demanding than other psychiatric fields because of the lack of support and backing, and as suitable for more experienced psychiatrists with a special interest in developing services or working closely with patients outside of hospitals. A further complication over the past 5–10 years has been perceived and real fragmentation of community services into assertive outreach, continuing care, crisis resolution and so on. These subsidiary functions of CMHTs have led to fossilisation and pulling up of the drawbridges (to mix metaphors) and teams are putting up barriers and refusing access to patients who do not meet their 'neat and tidy' criteria.

Trainees' responsibilities

Valsraj & Lygo-Baker rightly place much emphasis on the role of Modernising Medical Careers and PMETB in influencing the changes in training. That said, expectations from the new curriculum are that trainees will be responsible for holding their

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portfolios, having their competencies signed off and identifying for themselves what is good for their careers and what is not. This is both good and bad. It is good because students will hold responsibility for identifying their needs and matching competencies. It is not good because this repsonsibility and paperwork may be too much for some trainees. Often external pointers can show us shortcomings to which we remain blind, hence the value of 360-degree assessment, peer review and appraisal.

Competition, competencies and capability

The competencies required for managing community psychiatry are common to a large number of specialties within psychiatry. By focusing on a narrow field, there is a real danger that we concentrate more on ticking boxes against activities than on actual learning. Likewise, service development skills are crucial in all areas of psychiatric service provision. Multidisciplinary, domiciliary and emergency assessments and multidisciplinary planning are no different in community psychiatry than in any other psychiatric sub-specialty. The issues of poor resourcing, stigma and public expectations are much the same as in other branches of psychiatry. What makes community psychiatry special is its location and the closer interaction with CMHT members and professionals from other disciplines.

For services in the community to develop and thrive, trainers and trainees have to respond not only with core competencies that are expected of every trainee but also with skills in service development. The curriculum should not be seen as the end of it all, but only as the means to an end, so that the consultants of the future are able to deliver services that are acceptable to our patients.

Declaration of interest

D.B. is Dean of the Royal College of Psychiatrists.

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