Trainees Forum

A Regional Course on Interview Skills for Trainee Psychiatrists Preparing for the MRCPsych Part I Examination: Description and Evaluation

LYNNE M. DRUMMOND, Consultant Psychiatrist and Senior Lecturer in Behavioural Psychotherapy, St George's Hospital and Medical School, Cranmer Terrace, London SW17 0RE; KINGSLEY R. W. NORTON, Consultant Psychiatrist and Clinical Tutor, Belmont Postgraduate Psychiatric Centre, Sutton Hospital, Surrey; JOHN K. PRESTON, formerly Senior Clinical Psychologist, St Francis Hospital, Haywards Heath, Sussex; and ASHOK V. BHAT, Honorary Lecturer in Biostatistics, St George's Hospital and Medical School, Cranmer Terrace, London SW17 0RE

In October 1987, the new Part I of the MRCPsych examination was introduced. One aim of the College in changing the Preliminary Test, which had been introduced in 1971, was to create a more appropriate screening procedure so that those who are unsuited to psychiatry can receive career advice at an early stage in their career.[1] To this end there has been a shift in emphasis away from the basic sciences towards clinical psychiatry. The major change in format of the examination is the removal of the essay paper and the introduction of a clinical examination. In order to qualify to enter for the new Part I examination, candidates have to submit sponsor forms signed by a consultant for whom they have worked and by their clinical tutor. The sponsors are asked to certify that the candidate has been able to attend an appropriate course of instruction and has received training in interview skills.

With the relative paucity of physical signs of mental illness, psychiatric diagnosis and treatment relies heavily on doctors being able to establish good rapport, obtain often sensitive information and communicate well with patients. It is, therefore, surprising that there has been relatively little work reported in the literature on the training of junior psychiatrists in these basic clinical communication skills. Most of the work which has been reported has concentrated on teaching more specific psychotherapeutic skills.

Maguire *et al*[2,3] reported the value of specific training in interview techniques on the information gathering skills of medical students. They found that video feedback sessions, in which the students' performance during a prerecorded interview with a patient was commented on by an experienced interviewer, was an important part of this training.[2] The improvement in interview techniques gained by these students persisted into their postgraduate practice.[3]

It has been demonstrated that doctors become fixed in their style of interviewing soon after qualifying.[4] In light of these findings, the importance of ensuring that trainee psychiatrists receive adequate interview skills training early in their career becomes clear.

Interview skills workshops held at the South West Thames Regional MRCPsych Part I Day Release Course

The MRCPsych Part I day release course is held weekly for 20 weeks a year. It is well attended by trainees from throughout the South West Thames Region. With the introduction of the new examination occurring in October 1987, interview workshops were introduced for six whole days of the course beginning in October 1986.

We decided that the workshops should concentrate on the trainees learning by personal experience, both during the workshops and by monitoring their own clinical practice, rather than by didactic teaching. For this reason lectures in interview techniques were kept to a minimum with emphasis on role play and feedback from both course teachers and peers and seminar discussion. Demonstration videotapes of both effective and ineffective or poor interview skills were prepared by the course teachers and used as a springboard for discussion and appraisal by trainees. In addition, trainees were required to perform 'homework' between sessions which included making a videotape recording of themselves which they were asked to view and to ask their colleagues to comment on their performances.

Throughout the course we encouraged the trainees to appraise skills in objective terms and to describe specific behaviours used by interviewers. For example, instead of describing an interviewer as empathic, trainees were asked to describe the components of the interviewer's verbal and non-verbal behaviour which conveyed empathy.

The workshops were designed to cover a wide range of topics relevant to interviewing. These included: role of room setting, lighting and seating; non-verbal communication (including the role of sex and cultural background of interviewer and interviewee); self-introduction and orienting the patient to the purpose and form of interview; use of open and closed questions, verbal encouragement, summarising, reflection and hypothesis testing; different styles of interviews; behavioural analysis; dealing with the difficult interview (including the reluctant or aggressive patient

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and dealing with difficult subjects including sexual history); interview and social skills when relating to colleagues; examination technique (including mock Part I clinical examinations).

Method of data collection and assessment measures

For the purpose of the workshops each trainee was issued with a personal identification number (PIN). This number was unknown to the course organisers and was used by the trainees for completing their rating scales throughout the course. The use of the PIN was to maintain trainees' confidentiality and to increase the accuracy of the feedback information given by trainees. It could not, however, be used in the videotape assessments, and for this reason self-report data obtained from trainees could not be compared with their videotape performance data.

A number of measures were used to assess the effectiveness of the course:

(1) *Background information questionnaire* (Session 1)

This questionnaire was completed by trainees on their first day of attendance at the workshops and asked about the length of time they had spent in psychiatry and their previous experience of any training in interviewing techniques.

(2) *Videotape of interview* (Session 1 and Session 6)

Each course participant was recorded on videotape during the first interview skills workshop and again at the end of the course. These interviews lasted for five minutes during which time the trainee was asked to concentrate on obtaining the history of the presenting complaint. To achieve greater consistency and therefore better comparisons between trainees and in their pre- and post-course performance, it was decided that one of the course teachers (LD) should role play the same 'patient' for all interviews.

At the end of the course these videotapes were randomly coded and three consultant psychiatrists, who had not previously been involved in the course, were individually asked to rate the trainees' performances. In order to maintain the raters' 'blindness', care had been taken when filming the interviews that there was no clue, other than the trainees' performances, which videotapes were filmed at initial or final interviews. For example, the 'patient' wore identical clothes on both occasions and the interview was conducted in the same room with the camera in the same position.

The rating scales which the consultant psychiatrists were asked to use were the same as those used by Maguire *et al*[2,3] except that, as these workers had been assessing much longer interviews, some of the categories, such as those relating to finishing the interview, were excluded. Also we felt that, rather than use a variable rating scale, we would rate all items on a 0–3 scale.

(3) *Assessment of workshops* (All sessions)

At the end of each workshop each participant trainee was asked to complete a number of visual analogue scales. These scales recorded how useful–useless; boring–interesting; relevant to clinical practice–not relevant to clinical practice; relevant to MRCPsych–not relevant to MRCPsych, each session and its various components were felt to be.

(4) *Final questionnaire* (Session 6)

Visual analogue scales were used as before but the trainees were asked to rate their overall assessment of the series of workshops.

The findings

Attendance

Inevitably, some of the trainees on the course were sitting the old Preliminary Test. Nevertheless most of these trainees chose to attend the workshops that occurred prior to their taking the examination. There were six trainees who were attending the day release course and due to sit the Preliminary Test, three of these attended the initial interview skills teaching sessions prior to their examination, one trainee continued to attend the sessions despite having sat the examination. Only two trainees due to sit the old Preliminary Test did not attend any of the sessions and are therefore not included in the data collection or analysis. In addition, two trainees joined the day release course during the second term. It was felt that as these trainees could only attend the last two of the interview skills workshops, no data should be included from them in the present study. These trainees are also excluded from the attendance figures below.

Sixteen trainees attended at least one of the interview skills workshops. Of these, eight (50%) attended more than three of the six workshops. For the purposes of analysis of the data, it was decided that dropouts should be defined as those trainees who attended three or less of the workshops.

Attendance dropped during the course, with 14 (87.5%) trainees attending Sessions 1 and 2; nine (56.2%) attending Sessions 3 and 4; seven (43.7%) Session 5 and only three (18.7%) attending Session 6. To ensure that, in light of the poor attendance at the final session, adequate data for analysis were obtained, attempts were made to follow up those trainees who failed to attend session 6 and they were asked to complete the final questionnaires and to complete the final video. Ten (62.5%) trainees completed both the initial and final questionnaires and video interview.

Background information questionnaire

Fifteen (93.8%) of the 16 trainees were senior house officers in psychiatry with one trainee at registrar grade. They were working at five of the post-graduate training rotations in the South West Thames Region. Seven (43.8%) of the trainees were based at one of the three training rotations which include working at the St George's Hospital group. Nine (56.2%) of the trainees had been working in psychiatry for less than six months; six (37.5%) for between six and 12 months and only one trainee (who was sitting the old Preliminary Test and did not attend the final sessions) for between two and three years. Half of the sample reported that they previously had received supervised instruction in interview techniques which had been part of their undergraduate training. This apparently high number of doctors who had received such training may well reflect the increased attention to teaching these skills to undergrad-

uates in recent years.[2,3] However, none of the trainees reported that they had received more than six hours of lectures or supervised practice of interview techniques.

Videotapes of interviews

Thirteen (81.2%) of the trainees were recorded on videotape at the commencement of the course and 10 (62.5%) were also recorded at the end of the course.

Three consultant psychiatrists, blind to which were the initial or final videotapes, rated the trainees' performances independently. Using Pearson's correlation coefficient, no correlation or trend was found in the reliability between these three sets of ratings. For this reason, it was impossible to comment on the effect of the workshops on the trainees performance in the mock clinical interview setting.

Assessment of workshops and final questionnaire

The trainees reported that they found each of the workshops and the various components useful, interesting, relevant to their clinical practice and relevant to MRCPsych. For example, the 10 trainees who completed the final questionnaire rated the series of workshops as a mean 85.5% useful (range 77–95%; standard deviation 6.5); 78.9% interesting (range 48–94%; standard deviation 14.9); 86.8% relevant to MRCPsych (range 73–96%; standard deviation 7.4) and 81.5% relevant to clinical practice (range 55–94%; standard deviation 13.7). These ratings were similar to those reported for each of the individual workshops and for their various components.

Dropouts did not differ from those trainees who continued to attend in their appreciation of the workshops. Indeed, in the ratings of Session 1, dropouts reported that they found the workshop more relevant to clinical practice and MRCPsych (t-test, $P<0.05$). This finding may well reflect the fact that many of the dropouts were sitting the old Preliminary Test and had generally spent longer in psychiatry than the other trainees and may, therefore, have appreciated a course aimed at common clinical difficulties more in the light of their own experiences.

Comments

This paper demonstrates that trainee psychiatrists working for the MRCPsych Part I examination welcome the introduction of interview skills training in the Regional Training Course. Although the College insists that trainees should receive some instruction in interviewing before entering the Part I examination, it does not state what form such training should take. There may be a tendency for some consultant psychiatrists to assume that this training is an integral part of the apprentice system of training junior doctors and that an organised course in these skills is unnecessary. The current paper demonstrates that most trainees value a specific organised course aimed at improving these skills.

The dropout rate appears, at first sight, to be high. Three of these dropouts were, in fact, trainees who were sitting the old Preliminary Test and had, therefore, sat their examination before the end of the course and were no longer eligible to attend. However, this did not apply to the remaining five of the dropouts. No predicting factors for dropouts were found and these trainees valued the teaching sessions as much as attenders. Other workers have reported the difficulty in maintaining trainees' attendance at teaching events which are seen as voluntary.[5,6] Trainee psychiatrists are often required to fulfil a heavy service commitment and teaching events are often perceived as being of less importance by trainees. It is therefore necessary that the importance of such training is perceived and emphasised to junior doctors by their senior colleagues. The effect of consultants' attitudes to training on their junior doctors has been discussed elsewhere.[5,6,7]

The finding that there was no consistency between the assessment of the trainees' performances on video by three consultant psychiatrists is initially surprising. The rating scale used in this study was only slightly altered from that developed and used by Maguire *et al*[2,3] who reported an inter-rater reliability of approximately 90%. There were, however, three main differences between the present study and those performed by Maguire *et al*. Firstly, they were using the scales to rate the performance of medical students[2] or newly qualified doctors with a wide range of specialty interest.[3] It could be argued that, as the present study concerned trainee career psychiatrists, these trainees may have been attracted to psychiatry due to their having already discovered an ability to relate well with patients and, therefore, the rating scale was not sufficiently sensitive to distinguish between trainees. Secondly, the trainees in our study were asked to interview the patient for five minutes whereas a 15 minute interview was used by Maguire *et al*.[3] This shorter interview may not have been long enough to obtain a true assessment of the trainees' capabilities and therefore insufficient to obtain consistency between assessors. Lastly, in Maguire *et al*'s study[3] the assessors of the videotaped interviews were members of the department where the interview training course had been developed. It may therefore be expected that the assessors had information about the structure and format of the course and may well have held similar views as to the structure of a 'good' interview to those of the teachers. In our study, however, we used consultant psychiatrists who had not been associated with the planning of the course. Also, they received no instruction on how to use the measures and how they were to define the different components of the interviews.

This situation may be expected to be similar to that of the examiners of the College who have, likewise, a wide range of experience in specific interviewing techniques. The College has foreseen this difficulty and has run a number of 'induction days' for examiners and clinical tutors. Our finding of no consistency between different consultant psychiatrists' assessments of trainees' performance emphasises the need for such training programmes for College examiners if the examination is to be a fair and objective test of trainees' abilities. There have also been recent courses for clinical tutors to develop further their own interview skills and to help them to teach their trainees.[8] It would appear that such courses will continue to have an important place in the further education of senior psychiatrists.

There are many methodological problems inherent in attempting to demonstrate that an educational course is meeting its objectives. Our present study reflects some of these. Not least of the problems is that, in any day release course spread over several months, the trainees are inevitably learning by their everyday clinical experience as well as the formal teaching they receive on the course. Nevertheless, attempts to evaluate the applicability and value of training courses is important if we are to avoid costly and inappropriate teaching.

The current study demonstrates that a structured interview skills course was perceived as useful and of clinical and educational value by trainee psychiatrists. One further measure of its success or otherwise is in the proportion of trainees who pass the Part I at their first attempt. Seven of the trainees who attended the interview skills workshops sat the Part I examination in October 1987. These trainees had all attended three or more workshops. Six (85.7%) passed at this first attempt. The one trainee who failed the examination passed the clinical section and failed on the MCQ paper. Although it is impossible to attribute this high success rate to any one factor, it is at least reassuring that our trainees were so successful.

The ultimate value of all medical education must be in producing clinically skilled, sensitive and knowledgeable doctors. However, the assessment of how much clinical courses may specifically contribute to this objective is beyond the scope of this present study. Considerable work remains to be done in addressing the issue of designing objective measures to evaluate clinical skills.

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A full list of references is available from Dr Drummond on request.

Organising the MRCPsych Part I Clinical Examination

G. H. McDONALD, Senior Registrar, Purdysburn Hospital, Belfast; O. DALY, Senior House Officer, Royal Victoria Hospital, Belfast and C. CASSIDY, Registrar, Purdysburn Hospital, Saintfield Road, Belfast

In Autumn 1987 the new Part I Membership examination was held for the first time. The format was changed in response to the Royal College of Psychiatrists Working Party, who recommended that it should become an examination in basic clinical psychiatry.[1] It was felt to be important that clinical skills were assessed early in training.

To a certain extent, those of us involved in organising the clinical part of the new examination were entering virgin territory as the requirements are different to those of the new membership clinical examination. We believe it would be helpful to future organisers to discuss our experiences and point out some of the possible pitfalls in the administration of the examination.

Useful information can be gathered from the experience of organisers in other medical specialities where clinical examinations are used.[2,3] Advice may also be sought from those who have co-ordinated the MRCPsych II examination. It is interesting that Armstrong & Loosemore[4] report similar experiences to our own.

Each of the examination centres throughout the British Isles accommodates up to 32 candidates over two days. They are examined by two pairs of examiners from outside the region. On one of the examination days a College observer attends, with the remit of examining the suitability of the examination centre, the performance of the examiners, and the suitability of the patients selected. Although not directly examining the candidates, it can be presumed that his incursion will increase their anxiety level. At local level the examination is co-ordinated by a senior organiser appointed by the College. The senior organiser (a local consultant) in turn selects an organiser (senior registrar) and two stewards (registrar/SHO).

Before the examination

Planning the examination involves considerable disruptions to the host hospital. Permission to hold the examination must be sought from Unit Management who will then