MENTAL HEALTH POLICY PAPER

Psychiatric training in the UK: the next steps

DINESH BHUGRA

Institute of Psychiatry, De Crespigny Park, London SE5 8AF, UK

Postgraduate education and training in the UK is undergoing tremendous change. In this paper the changes affecting psychiatry are described, with an account of the drivers. Patients, their carers and politicians all expect psychiatric service providers to have certain characteristics. Psychiatric training is becoming more competency focused and it is right that assessments of competencies also occur at the place that trainees work. There are key competencies that trainees need to take into account while learning and working. These are described along with the way forward.

Key words: Psychiatric training, postgraduate education, assessments, capabilities of psychiatrists, competencies

(World Psychiatry 2008;7:117-118)

Psychiatry is one of the key medical specialties, which has close relationships with non-medical mental health disciplines, biology and primary care medicine. In order for psychiatry to succeed as a profession, it has to demonstrate its effectiveness in dealing with mental illness and distress and must rise above the “psycho babble” of pop psychology. The role of the psychiatrist must include educating the public, other physicians and legislators as well as employers, and has changed dramatically in the last fifty years or so, as services have evolved and changed.

Twenty years ago, it was pointed out that being a good psychiatrist requires understanding of the patient’s and one’s own subjective responses; objective approach to behaviour; ability to make contact with psychiatric patients; understanding of signs, symptoms and syndromes; ability to conduct and organize investigations and treatment methods using physical, psychological and social approaches, and an understanding of the self (1). Since then, little has changed and these characteristics remain important for the ideal psychiatrist. However, several other competencies have recently emerged as essential and are listed in Table 1.

The recent growth of subspecialties, the changes in undergraduate education, the arrival of increasing numbers of international medical graduates in the UK and the structural changes within the National Health Service and medical pro-

fession all indicate that the time is ripe to look at the training needs and change our delivery of training accordingly. Any training relies on resources, both human and financial. The roles of the trainers and scheme organizers as well as directors of medical education and programme directors cannot be carried out unless clear resources are identified and the time provided for training and supervision is recompensed adequately. The educational and clinical supervisors need time for these activities, which have to be enshrined in their job plans. At the same time these activities must also be evaluated.

THE PSYCHIATRIST OF THE FUTURE

The psychiatrist of the future will need a range of competencies in clinical, management, teaching, research and other areas. The impact of documents such as “The Ten Essential Shared Capabilities” (2) cannot be overestimated. These are as follows:

- 1. 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 interests or aspirations that may arise between the partners in care.
- 2. 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, sex, race, culture, disability, spirituality and sexuality.
- 3. Practising ethically. Recognizing the rights and aspirations of service users and their families, acknowledging power differentials and minimizing 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.
- 4. Challenging inequality. Addressing the causes and consequences of stigma, discrimination, social inequality

Table 1 Core attributes of a good psychiatrist

1. Clinical competence
2. Being a good communicator and listener
3. Being sensitive to gender, ethnicity and culture
4. Commitment to equality and working with diversity
5. Having a basic understanding of group dynamics
6. Being able to facilitate an atmosphere within a team
7. Ability to be decisive
8. Ability to appraise staff
9. Basic understanding of operational management
10. Understanding and acknowledging the role and status of vulnerable patients
11. Bringing empathy, encouragement and hope to patients and carers
12. Critical self awareness of emotional responses to clinical situations
13. Being aware of potentially destructive influences in power relationship
14. Acknowledging situations where there is potential for bullying

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.

5. *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.
6. *Identifying people's needs and strengths.* Working in partnership to gather information on health and social care needs in the context of the preferred lifestyle and aspirations of service users, their families, carers and friends.
7. *Providing patient 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.
8. *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.
9. *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.
10. *Personal development and learning.* Keeping up-to-date with changes in practice and participating in life-long learning, personal and professional development for one's self and colleagues through supervision, appraisal and reflective practice.

The training to produce good psychiatrists has to incorporate these characteristics, which are not attained sequentially, but as building blocks where more than one capability can be reached at any given time.

A NEW FOCUS IN TRAINING

The focus in training in the UK shifted to self-directed learning where the trainees take on the responsibility for their training and optimizing the limited contact between trainers and trainees. In examining, the trainee log book will become an important component of overall assessment. The teaching will have three components: patient-based (ward rounds, topic-based bedside teaching, outpatient-based teaching, case conferences, psychotherapy, audit and clinical governance); classroom-based teaching (web-based learning, didactic teaching, journal clubs), and learner-based learning (educational supervision directly or indirect-

ly 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 by apprenticeship, and formal documentation such as log book or portfolio of competencies achieved will be the core of the future assessments. Individual patient assessments, be they based on the wards or in outpatient departments, will be assessed using direct observation and video links with reflective analysis as well as problem-based learning.

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

Educational supervision will follow the FY2 (second Foundation Year) principles, 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 to by the employers. It is expected that each educational supervisor will have between 8-10 trainees who are not necessarily supervised at the same time, but 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 e-mail, webcam, video conferencing, etc.

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

CONCLUSIONS

Psychiatric training is becoming more competency focused and it is right that assessments of competencies also occur at the place that trainees work. There are key competencies that trainees need to take into account while learning and working. Skills such as understanding the patient's world and taking full cognisance of biological, psychological, physical and spiritual factors in the aetiology as well as management of the distress have to be developed. Cultural sensitivity and communication with patients and their carers are important and some of these skills are innate whereas others can be learnt. The educational principles must focus on outcome with defined competencies, otherwise the shift to competency based learning and assessment will fail.

References

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2. Skills for health. Essential shared capabilities. www.skillsforhealth.org.uk/mentalhealth/esc.php.