Training of Psychiatrists: Prospects and Alternatives

The following papers (pages 63 to 68) were presented at the Annual Meeting of the Association of University Teachers of Psychiatry on 19 September 1980

The Future of the Membership

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The question has been posed—is an examination necessary to admit to the membership of the Royal College of Psychiatrists? The College represents the views of psychiatrists, maintains the standards of the profession, regulates and monitors practise and accepts a broad overall responsibility for education. It should admit to its membership those who practice as psychiatrists. Who then are the psychiatrists? Should the membership be open to anyone who makes such a claim or should it be linked with appointment to specific jobs as a psychiatrist at a level yet to be determined? What of private practitioners, interested GPs? Surely anyone who wants to be a psychiatrist, to paraphrase Sam Goldwyn, ought to have his head examined by his peers to establish that his claim to be a psychiatrist is acceptable. It is the College which should regulate entry into the profession of psychiatry, not the National Health Service, an employing authority, or even the universities. Some membership entrance conditions are needed which lay down minimum requirements for becoming a psychiatrist and it is important to exclude or reject, in my view, before higher psychiatric training commences.

We should be able to ensure that aspiring members are exposed to appropriate supervised experience over a specified period, to an appropriate educational programme and to stimulation and encouragement, and we should expect the candidate to demonstrate that he has benefited from these provisions.

The road which has been chosen to secure improvement in training facilities and programmes is that of the evaluation or approval of the training programmes themselves. We now require that a psychiatrist should have a minimum experience and that this should be secured in approved posts or schemes. This requirement is a perfectly proper one, but is it enough?

Particularly with current employment protection regulations, occupation of a post is not synonymous with gaining optimal, or even any, benefit from it. Continuous assessment is impracticable because of a variety of factors, the most important of which are probably difficulty in achieving reasonable standards over the country, the susceptibility to local pressures ('all of *our* registrars get through'), the difficulty in setting up a valid and effective monitoring process and the large number of individuals who would be involved. How can we have confidence in a continuous assessment programme when 55 per cent of trainees can claim that they never see their clinical tutor to discuss their progress, 52 per cent that they have never been taught how to make a formulation and 43 per cent that they have never been taught how to perform a mental state examination (APIT, Newsletter 1979).

There could be a system of personal accreditation, involving some form of extended continuous assessment and incorporating specific requirements regarding experience, to be evaluated by some body or group appointed for this purpose. I suggest that this process would be not only bureaucratic and cumbersome, but would have all the disadvantages associated with continuous assessment.

Something else is required, and I would suggest that at the present time some form of examination is probably the best means available to us.

Objections to the present examination include:

1. The fact that APIT is or was opposed to the examination in principle.
2. That it is neither an entry examination like the MRCP nor an exit examination like the MRC Path.
3. The lack of agreed standards and variation between examiners is unfair.
4. The present examination needs 'tinkering' or readjustment, such as the definition of a syllabus, especially for the Preliminary Test, and the introduction of video recordings.
5. A drastic reappraisal and restructuring of the examination is required.

Numbers 4 and 5 are particularly emphasized by those who regard the present examination as difficult to prepare for and a disincentive to involvement in psychiatric practice.

There are some who object to the MCQ examination on the grounds that, though the questions may be reliable and predictive, they may be neither valid nor comprehensive, and that many candidates have specific difficulty with this form of examination. Others object to the essays, and here criticism is easy to sustain, with poor agreement between markers, poor standards of literacy and limited range of sampling of knowledge.

Perhaps we can look briefly at what other colleges do. The MRCP is said to be largely clinical and 'selects those suitable for higher training'. Many registrar posts in medicine virtually require the MRCP as a condition of appointment and it is not regarded as marking the completion of general professional training. The FFARCS may be taken four years after qualification and after not less than two years full-time anaesthetic posts. The MRCOG and the FRCR may each be taken after three years in an approved post, and the FRCS after four years. These then might be regarded as marking the completion of general professional training. The

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Royal Australian and New Zealand College (RANZCP) demands five years of psychiatric training, though the examination may be taken after three years.

The College of Pathologists alone has what can be described as an exit examination which marks the end of higher training in pathology, but already they are concerned that this may be a major disincentive in recruitment. Many trainees have complained that difficulties with the examination at the end of higher training create an impossible situation for many candidates.

Our own NHS and educational structure does lend itself to an advanced progression. Graduation is followed by one year of pre-registration posts the completion of which gives the individual the right to practise. Shortly afterwards the individual embarks upon general professional training, which is usually within a specialty, but in theory is pluripotential. Nothing should be done to a doctor during the four or so years of GPT that would actually disqualify him from practice in any branch of medicine. On the completion of GPT he embarks upon higher professional training which is discussed in another paper by Professor Kendell.

I suggest that entry into higher professional training identifies an individual as a psychiatrist or specialist practitioner who, given reasonable application, should be able to complete his higher training and become a fully trained psychiatrist eligible for consultant status. If that is so we must ensure that at entry into higher training the individual has in the broadest terms shown himself to be capable of benefiting from training and has aptitude for practice as a psychiatrist. Ideally he should have the basic knowledge, attitude and skills which fit him for membership of this professional group.

Our task then is to develop a system which enables us to evaluate the individual and his training.

At present our model is of three years general professional training, followed by four years of higher professional training. What can we hope to achieve during that three years? What sort of performance should we expect at the end of general professional training and how can we test it? Equally important is how can we arrange our assessments in such a way that they are a stimulus rather than an impediment to clinical practice?

First, we must continue to insist on three years of relevant clinical experience in posts which are recognized as providing good and appropriate experience. The College approval exercise is the instrument designed to improve and approve these posts, the clinical tutor or training committee will counsel the individual on the proper balance of his training, with the Dean and Court of Electors maintaining an overview.

Second, we encourage the trainee to attend academic instruction, developed in parallel with the training posts, which lead to an appropriate exposure to the recommended range of academic topics. So far we have not insisted on completion of such a course, no 'residence' is required other than that associated with the posts—but let us return to this later.

Third, we have an examination. Can this evaluate or test the knowledge, skills and attitudes of those who have acquired the experience and attended the recommended courses? Though an imperfect instrument, I suggest that a modified membership examination is the closest we can get to such a requirement at the present time. However, we must ensure not only that it tests or evaluates the individual's current achievement but that preparation for it should stimulate, broaden and encourage his interest rather than unduly restrict it.

Let us, then, examine the Preliminary Test. What is its purpose? First, it should be a screen designed to eliminate those whose level of ability, application or temperament disqualify them from psychiatric practice. Let us discount temperament. Those unsuited for practice will not be identified by an examination at this stage, and we must rely upon consultant supervisors and clinical tutors to identify and counsel those who are unsuitable, and hope that the major clinical examination will further reduce the numbers who inappropriately enter higher training. It is not unreasonable to set a cognitive test of achievement of a minimal level of knowledge in designated areas. The most appropriate content at this stage probably consists of the biological and behavioural foundations to psychiatry. Since we also expect the individual to have some commitment to learning basic psychiatry at this stage, we should include some aspects of clinical practice—perhaps little more than at undergraduate level. Frequently, on examining undergraduates in various parts of the country, I have to agree with my fellow examiners that we would be pleased to see candidates of such a quality in the Membership Examination.

How can this be examined? Since it is to be largely factual, either or both an MCQ or essay-type examination is possible. The present MCQ is reliable and convenient, but as already mentioned reservations have been expressed as to whether it is either valid or comprehensive. It does correlate quite well with eventual outcome and I know of no evidence that MCQ tests exclude people of ability. Those without experience of MCQs can easily acquire training and experience in their use (Hassall and Trethowan, 1978).

The present Preliminary Test essay is a single question intended to give candidates scope to demonstrate their brilliance, creativity, literary style and depth of knowledge. In practice it plumbs other and murkier depths. There can be few who believe that its continuation can be justified.

Instead, I suggest that an MCQ ranging over the current topics of (1) neurobiology and genetics; (2) psychology, statistics and child development and (3) general and dynamic psychopathology should have added to it on clinical psychiatry, psychopharmacology and treatment methods in general medicine. The present essay paper should be abolished and replaced by short-answer questions and progressive patient management problems.

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More debatable is whether a pass mark overall on this examination should be followed by a simple clinical examination. I personally doubt whether this could reliably test attitudes or skills at this stage and I think we might do better to rely on tutors and academic teachers to identify those with problems in these areas.

I would suggest that this should be a pass/fail examination without viva, and that trainees should be advised to take it after one year in psychiatry but *allowed* to take it at any time regardless of their occupation and training but not less than one year after full registration, with some similar arrangement for foreign graduates. This would enable doctors from overseas or those with domestic responsibilities to attempt the examination while still working on a part-time basis or even without formal employment in psychiatry. It might also serve to net for psychiatry a few who are uncertain whether to embark on a formal course of training.

The Membership Examination should concentrate on examining clinical skills, knowledge and attitudes. If the either/or 'perm three from four' type of knowledge has been tested by MCQ in the Preliminary Test, the written paper could range over clinical issues and problems in short essay questions. This would enable us to test over a range of knowledge and allow expression of opinion and attitude. The clinical examination should remain the central part of the examination, and I would resist any effort to replace the patient by electronic images or computer simulation. Many people could arrive at a respectable formulation and treatment programme watching a video of, say, Neil Kessel interviewing a patient and offering cues as to how he thinks things should proceed from there and yet be totally unable to extract and distil this information when confronted by an actual patient. The video method is an ideal way of demonstrating dyskinesia or an abnormal gait, Gilles de la Tourette's syndrome or phenothiazine pigmentation, but if we wish to continue to cherish clinical excellence the candidate must face a patient himself. The examiner should, however, have some opportunity for observing this process. A strong case could be made for two separate long cases with two different pairs of examiners, but I suspect the cost would be prohibitive. We could certainly add an extended viva which included a videotape presentation of short cases.

The one area which I believe we must extend, however, is medicine in relation to psychiatry. This in my view should be represented at an undergraduate level in the Preliminary Test, in the essay paper and in the clinical. A major medical Membership-type clinical examination is beyond our resources, but we could follow the outline laid down by Dr Harden of ASME of a 'stations' examination, with candidates moving in succession from one station to another, each with a requirement to perform a simple examination or make a judgement from available information. Alternatively, we might rely on videotape demonstrations of history and physical signs. Finally, a viva which would have a pass/fail function for marginal candidates but would either be omitted or become a formality for those with a comfortable pass.

Now, when should this examination be taken? I suggest after the Preliminary Test and not before two years of post-registration experience including a minimum of one year in approved psychiatric training posts, together with one year in psychiatry, research, or psychiatrically relevant clinical practice.

However, in order to become a Member of the College the candidate should be required to (1) pass the Preliminary Test (2) pass the Membership Examination (3) complete three years of approved general training including attendance at a recognized clinical course for nine terms. Possibly some arrangement for recognizing overseas experience and supplementary intensive academic courses could be worked out.

As a *rite de passage* to final Membership, one might require presentation of a psychiatric experience book which itemized various types of experience to be certified by the appropriate tutor as having been acquired by the trainee and possibly included one or more case records which would form the basis of the final viva.

To make such a system viable, however, two reforms of the present arrangement would also be required. First, selection and training of examiners should be extended to include a two-day residential course on appointment with monitoring and discussions of level of agreements between examiners and the dropping of those with deviant scores or practices. Secondly, involvement of the tutors or the universities in the assessment and counselling of those who fail any part of the examination three times. This should be done in order that the fourth and final attempts occur after educational guidance and intervention.

Any of these changes will require more money and this must come largely from the candidates themselves. The Preliminary Test may encourage more 'have a go' candidates from home and overseas, but this would be no bad thing provided it acted as a reasonable screening test for entry into training. It should not be too difficult to organize, it might provide a source of money to finance the more expensive Membership; it might bring into psychiatry some tryers encouraged by an early success, and it could be got out of the way soon by the brighter candidates. They should still have to have exposure to the experiential and educational aspects of a training programme and pass a major clinical.

We might also consider here whether the different fields of psychiatry should be represented by a specialist section of the MRCPsych. Child psychiatry, psychotherapy, forensic, adolescent, psychogeriatric, subnormality, epidemiological, middle aged, feminist—there is no end to the categories which might long for special representation in the Membership. At present I do not believe there is any psychiatric specialty which is not or should not be firmly rooted in general psychiatry and for which general psychiatric professional training is not the main foundation for specialization. Let the bright child psychiatrist do some

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child psychiatry at registrar level after completing his Membership Examination, but his overall training must be in general psychiatry.

If we do have a specialist element in the examination, and this would be against my advice, it should be in a fourth year programme. In the main, my plea is: let us improve training, the examination and the examiners, and hope that this results in better candidates in the future.

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Examination, Accreditation or Inspection?

By R. E. KENDELL,* Professor of Psychiatry, University of Edinburgh

What is the best way of maintaining and raising the quality of 'higher' (i.e. senior registrar) training, and the best way of ensuring that aspiring psychiatric specialists are competent to undertake the tasks ahead of them? Basically, three alternatives are available—examination, or 'accreditation' of individual trainees, or inspection of training posts—and my purpose is to discuss the advantages and disadvantages of these alternatives.

Examination

All medical specialties in this country have an examination (for the Membership or Fellowship of the Royal College concerned) at some stage in postgraduate training. Some, like the physicians, have an 'entry exam' which has to be passed before the candidate can begin specialist training. Others, like the pathologists, have an 'exit exam', in which success marks the completion of specialist training. At present the examination for the Membership of our College comes at the half way stage, at the end of 'general' (i.e. registrar) training but before starting 'higher' training. An examination at the end of higher training could, therefore, either be a replacement for or an addition to this existing exam. Either, it seems to me, would have grave disadvantages. Although many of our sister colleges have a two-part examination, as we do, none requires its recruits to pass two separate examinations, and there is little doubt that an additional examination at the end of higher training would be extremely unpopular with trainees and might well inhibit recruitment to our discipline. Moreover, because, at our own request, the Health Departments recognise five distinct types of psychiatrist and provide separate career structures for each, there would have to be five separate examinations, or at least five different specialist subjects. The most serious disadvantage of an 'exit examination', however, is that it is simply not feasible to say to a trainee after six or more years of specialized training that he is not good enough and must move into some other branch of medicine. Consequently, either everyone must pass the examination, which converts it into a pointless ritual, or it must be possible for those who fail to remain in psychiatric practice. In the United States this is possible. Partly because the examining body (the American Board of Psychiatry and Neurology) is quite distinct from the professional association (the American Psychiatric Association), and partly because a large proportion of American psychiatrists are private practitioners who do not need appointments in government hospitals, many American psychiatrists thrive happily without passing their Boards. Provided they are 'Board eligible' (i.e. have completed a recognized residency training) they are professionally secure. In the United Kingdom, however, this would not be possible unless the NHS provided a second subconsultant career structure for those who could not pass the exam, and the College itself was prepared either to exclude part of the profession from its activities or to create a second less exalted breed of Member. Lastly, it is important to remember, as Professor Brandon points out in another article, that the present Membership examination has many shortcomings which no one has yet been able to eliminate, and that there is a widespread feeling that it should come earlier rather than later in training.

Accreditation

This is the technical term for the formal designation of a medical practitioner as a registered specialist on completion of an approved programme of training. Most Western countries have some such system, the responsible body being either the Ministry of Health, or other government department, or a professional association analogous to our Royal Colleges. In the EEC, for example, specialist registration is conferred after four years of approved specialist training and any British graduate wishing to practise in another EEC country can obtain an appropriate certificate from the GMC if he has passed the College Membership examination and completed at least one year of senior registrar training. In this country the (Todd) Royal Commission on Medical Education recommended in 1968 that there should be 'a system of vocational registration as the necessary complement to a proper system of professional training', and that the General Medical Council 'should be the vocational registration authority'. This view was endorsed in 1975 by

* Although the author has been one of the College's representatives on the JCHPT since 1975 and chairman of the General Psychiatry SAC since 1978, the opinions expressed are his own.

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