

## Correspondence

### Two years after introduction, trainees remain unconvinced about WPBAs and ARCPs

Several surveys conducted in the first year after the introduction of workplace-based assessments (WPBAs) in 2007 show poor satisfaction with this process.<sup>1-3</sup> Our survey of trainees conducted in 2009 shows ongoing concerns with WPBAs 2 years on.

Of the 146 trainees who participated in our electronic survey, 40% did not feel that WPBAs had led to improvements in patient care, with 31% unsure. Furthermore, 68% considered that WPBAs did not help/were only slightly helpful to them in passing their MRCPsych examination. Of those who were in psychiatric training before WPBAs were introduced (67%), 70% reported no improvement in their training!

However, 88% of trainees rated their satisfaction reasonably high on the quality of feedback they received (at 3 or above on a 5-point Likert scale). Norcini & Burch<sup>4</sup> stress that formative assessment and feedback are a powerful means for changing behaviour in trainees, and that feedback can have a major influence on learning. On the face of it, our results seem strange, as trainees do not seem to acknowledge or recognise the helpfulness of this new method of assessment on their training experience.

The online filing of WPBA has improved greatly in 2008. The faulty Healthcare Assessment and Training computer system (originally in use to record WPBAs) can no longer be blamed for trainee dissatisfaction, as in earlier surveys.<sup>1</sup> Our concurrent survey of 50 consultant trainers showed that they too had ongoing concerns about WPBAs. In particular, 80% of trainers felt that WPBAs had an impact on their work commitments. If trainers were more positive about these assessments, perhaps this would influence their trainees' perceptions.

Parallel with the WPBA, the annual review of competence progression (ARCP) panels have been introduced. The ARCP should be an important formative and summative part of training. In our survey, 44% of trainees and 20% of trainers felt ARCPs were not meaningful, with 30% of trainees and 42% of trainers not sure.

We acknowledge that the interpretation of our survey is limited by the reasonably low take-up among trainees and trainers. Yet our results concur with those of Menon *et al*'s 2008 study<sup>1</sup> and therefore we feel that our survey cannot be simply ignored because of the low response rate.

We agree with Menon *et al*<sup>1</sup> that these new tools for evaluation and feedback should not be abandoned. However, further training of both trainers and trainees is needed to achieve better usage and a clearer understanding of the constructive role they should play in training, particularly with respect to the role of feedback.

Employers need to recognise that consultant psychiatrists require more time in their job plans for training future psychiatrists.

1 Menon S, Winston M, Sullivan G. Workplace-based assessment: survey of psychiatric trainees in Wales. *Psychiatr Bull* 2009; **33**: 468-74.

2 Babu KS, Htike MM, Cleak VE. Workplace-based assessments in Wessex: the first 6 months. *Psychiatr Bull* 2009; **33**: 474-8.

3 Pathan T, Salter M. Attitude to workplace-based assessment (letter). *Psychiatr Bull* 2008; **32**: 359.

4 Norcini J, Burch V. Workplace-based assessment as an educational tool: AMEE Guide No31. *Med Teach* 2007; **29**: 855-71.

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### The future of workplace-based assessments for core trainees

We were pleased to read the two surveys of trainees' and trainers' experiences of workplace-based assessments (WPBAs)<sup>1,2</sup> and the accompanying commentary<sup>3</sup> in which Femi Oyeboade neatly put his finger on some of the difficulties and challenges that have accompanied the College's adoption of these training tools. Inadequate training of hard-pressed trainers, lack of clarity concerning the relative importance of formative and summative functions, and the increasing bureaucratisation involved in the collection of portfolio evidence have all obscured the potential usefulness of the assessments. We thought that it would be useful for us to report how the College is planning to help trainees and trainers with the WPBAs for core training in the light of our own concerns and those reflected in the journal.

Delivery of anything more than the most superficial training in WPBAs to all clinical and educational supervisors has proved challenging. Consultant trainers are overwhelmingly conscientious about their responsibilities in delivering supervision and completing assessments but have found it hard to access WPBA trainer training. We have asked each of the Faculty Education and Curriculum Committees to produce a series of new standardised WPBAs, each one based on an important curriculum competency, and to provide a single-page trainer's guide to that specific assessment that will tell the trainer exactly what should be covered and what is expected from their trainee to complete the assessment satisfactorily. These 'set' assessments, together with the relevant trainer's guides, will appear in a few months on Assessments Online (<https://training.rcpsych.ac.uk>) when trainers and trainees log on to complete an assessment. Our hope is that this will provide in-service training for assessors as well as a series of WPBAs whose content is consistently high and focused upon acquisition of the most important curriculum competencies. The Chief Examiner has offered to provide Clinical Assessment of Skills and Competences (CASC) examiner training to interested trainers – even if they are not necessarily intending to examine – to help them to understand how their trainees will be expected to perform by the end of core training and to strengthen the robustness of their own assessments during supervision. We will be

advertising these opportunities shortly, so look out for this if you are interested.

Psychiatry has the MRCPsych examination as the principal summative assessment of satisfactory completion of core specialist training. This, we believe, remains a reliable and essential test of the acquisition of the knowledge and competencies expected of a psychiatrist who is ready to progress to higher training. The current rating system for WPBAs in Assessments Online, however, does not sufficiently emphasise the essentially formative function of the process. As a consequence, many trainers have found it difficult to give robust and honest feedback and we have all become aware of the phenomenon of the trainee with a portfolio of perfect WPBA scores, baffled by their failure to pass the CASC exam. We are investigating ways of making the scoring system simpler and more aligned with judgements based on satisfactory development of competences in maintaining patient safety.

Workplace-based assessments, if used correctly, can be a powerful formative training tool. At the very least, they provide an opportunity for trainees to have their practice and competencies observed in a protected and structured manner. The challenge for trainers, the College and trainees themselves is to embrace the cultural training change that WPBAs represent so that they are used to support effective training. Workplace-based assessments are primarily a tool for helping an experienced clinician give robust and valid feedback to another clinician. To treat them as a tick-box exercise is to miss the point and lose their value. Those of us responsible for guiding members and trainees through the new training mechanisms have probably not been sufficiently clear or realistic about what is expected from trainers and trainees and there has certainly been a lack of clarity about the overwhelmingly formative function of WPBAs. For this we are sorry. We are learning too, and hope that the changes that we have outlined in this letter will move things forward. The College, too, must expect to receive robust and valid feedback about training initiatives, and we hope that colleagues will continue to survey trainer and trainee experiences and that we will be seen to act constructively and purposefully in response. We all want the highest possible quality training for psychiatrists and have to make the best use of the tools available.

- 1 Menon S, Winston M, Sullivan G. Workplace-based assessment: survey of psychiatric trainees in Wales. *Psychiatr Bull* 2009; **33**: 468-74.
- 2 Babu KS, Htike MM, Cleak VE. Workplace-based assessments in Wessex: the first 6 months. *Psychiatr Bull* 2009; **33**: 474-8.
- 3 Oyeboode F. Competence or excellence? Invited commentary on... Workplace-based assessments in Wessex and Wales. *Psychiatr Bull* 2009; **33**: 478-9.

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## Medicalisation of stress belittles major mental illness

Few would argue with Professor Kingdon when he states that 'Everybody gets stressed . . . it's just the way we react that

differs'.<sup>1</sup> Indeed, as Kingdon asserts, there can be no doubt that continua exist between normality and certain states currently classified as mental disorders. However, the artificial dividing lines towards the ends of each spectrum, set purely by societal expectations, surely call into question the validity of those very diagnoses that have perpetuated the myth of massive unmet need in psychiatric services.<sup>2</sup> Rather than adopting a stress model of diagnosis based on dimensions, perhaps diagnoses such as mild depression, social phobia and personality disorder should instead be dispensed with altogether.

On the other hand, major mental illness is not primarily stress-induced. Although environmental risk factors exist for schizophrenia, bipolar and unipolar (endogenous) mood disorders and dementia, there is no convincing evidence to suggest that these illnesses are any more likely than peptic ulcer, cancer or myocardial infarction to be triggered by psychosocial stress.

Furthermore, in psychiatric practice, a diagnosis is not a checklist of symptoms; it is a process we have each spent many years learning to craft. Symptoms and signs such as hallucinations and delusions undoubtedly sit on continua, but it does not follow that schizophrenia sits on a similar continuum. Using Kingdon's analogy, chest pain may vary in aetiology and sit on a continuum of frequency and severity, but myocardial infarction remains a categorical diagnosis.

Lastly, one should not reconceptualise and reclassify mental disorder as a response to the stigma attached to it. If cardiac illness were to suddenly become stigmatised, I doubt physicians would rewrite the diagnostic criteria for myocardial infarction. On the contrary, diagnosis would remain necessary for both immediate and long-term management, and it would still be vitally important to separate those with cardiopathy from those without.

1 Kingdon D. Everybody gets stressed . . . it's just the way we react that differs. *Psychiatr Bull* 2009; **33**: 441-2.

2 Richman A, Barry A. More and more is less and less: the myth of massive psychiatric need. *Br J Psychiatry* 1985; **146**: 164-8.

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## Laughlin Prize winners: some further thoughts

It seems entirely reasonable to argue that the number of e-letters (letters submitted online to the journal in response to an article) and/or e-responses (email responses to the corresponding author) an article receives is a proxy measure of the interest generated by the article and also the wider interest in the journal. Albeit lacking the robustness of the 'impact factor', why not call this the journal 'interest factor'? Although letters to the editor are way down the 'importance' hierarchy of academic publications, my letter on the Laughlin Prize<sup>1</sup> still had six e-responses from trainees and four from the Laughlin Prize winners, hence my inference that *The Psychiatrist* probably has a high interest factor among its readers.

I give below an excerpt from an e-response I received from Professor McKeith, who won the Prize in 1981. I feel it is worth sharing because his eloquent, insightful and humble account answers three questions I set out to answer in my survey (to find out more about the winners, their preparation

for examination and whether winning the prize influenced their later career choice).

Tidying my office for Christmas I came across your letter in November's *Psychiatric Bulletin*. As [the Laughlin Prize] winner in 1981 I fall outside of your survey dates but am intrigued by it. I agree that it is a rather uncelebrated achievement and the personal characteristics of . . . winners may account for some of that. It did have an influence on me I think, although one never knows what the alternative future would have looked like. I have met three other Laughlinites who have passed through my Department and I also went to visit Dr Henry P. Laughlin and his wife when I worked in the [USA] on an RCPsych travelling fellowship. They were a delightful couple. For what it is worth I agree with your extrapolation from a small sample size that enjoying the exam contributes to success although I also think that there is a huge amount of luck involved. My recollection of the Membership Exam (as it then was) was of a good day out and of not being at all intimidated by my two very distinguished London based psychotherapist examiners. I suspect that I could do this because I had been fortunate enough to have been trained in a first class centre where I was used to such grillings and it was relatively easy to take the exam in my stride as no different to my normal daily routine.

- 1 George S. The 'special' ones: survey of Laughlin Prize winners (letter). *Psychiatr Bull* 2009; **33**: 438–9.

## Acknowledgement

I thank all e-respondents and in particular Professor Ian McKeith who allowed me to share his thoughts.

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## Empowerment and the recovery model

I would not argue against the underlying principles espoused by Sugarman *et al*<sup>1</sup> and Warner.<sup>2</sup> The principle of working with patients to help them to make informed decisions about options for their healthcare is embodied in the General Medical Council's (GMC) guidance,<sup>3</sup> which says that doctors must listen to and work in partnership with patients, and respond to their preferences.

Many psychiatric disorders are exacerbated or precipitated by stress. Autonomy of action is associated with enhanced self-esteem, reduced stress and improved health. Meaningful employment contributes in many ways, giving a sense of purpose and value, enhanced social status, structure and stability, opportunities for social interaction, and improved leisure and social opportunities as a result of greater disposable income.

Those working with individuals who have mental illness should be aware of these principles and seek to incorporate them in the care they offer. In practice, however, professionals nominally subscribing to a 'recovery model' may have a poor

understanding of its complexity. An inappropriate application of the concept of empowering patients can lead to a laissez-faire approach of simply endorsing the patient's choice. This can result in justifying a patient's discontinuation of treatment and withdrawal from engagement with professionals. Such withdrawal can lead to relapse and a deteriorating prognosis, and may itself be indicative of incipient relapse.

Professionals do not enjoy a monopoly of wisdom. We cannot reliably predict the course of a patient's illness or how they might respond to treatment. Those with capacity have the right to decide not to accept treatment or to deal with their illness in ways which professionals may consider unwise. However, GMC guidelines also say that doctors must provide effective treatments based on the best available evidence. The doctor's duty to provide the best advice may include advising a patient that their intended course of action is likely to lead to an adverse outcome. It is incumbent upon us to inform patients of the probable consequences of their decisions and to continue efforts to engage them when we consider them to be at significant risk of deterioration or relapse.

Additionally, UK and European law takes a special view of mental disorder and allows for the patient's autonomy to be overridden. It is a matter of judgement, governed by legislative safeguards, as to when this should occur. Such powers are generally only exercised when the patient's ability to understand is so impaired as to render them incapacitated but a decision to override the decision of a capable patient may be made when the protection of others is in question.

It is right to adopt a positive approach, hopeful of recovery, after a first episode of psychosis. However, rather than adopt unqualified optimism, we should refine our approach using our knowledge of factors favouring a good prognosis. Such features include: acute as opposed to insidious onset; clear and proximate psychogenesis; and the presence of marked affective features in the symptomatology. Several interventions can improve the prognosis and reduce the risk of relapse. Warner<sup>2</sup> points out the more favourable prognosis in low- and middle-income countries. One explanatory hypothesis is that the recovering patient is more likely to have a valued occupational role. Continued antipsychotic medication reduces the risk of relapse. Psychosocial interventions to assist the patient in better understanding the illness and its behaviour, as well as working to modify family attitudes and environments appear to help. Complete resolution of symptoms encourages optimism about prognosis, but hopes for a meaningful and lasting recovery need to be underpinned by appropriate support and treatment to reduce the risk of relapse.

Despite the advances made in treating the acute symptoms of schizophrenia and preventing acute relapse, social recovery rates do not appear to have improved since Eugen Bleuler coined the term schizophrenia.<sup>4</sup> Warner quotes a 40% social recovery level but, at the start of the 20th century, Bleuler considered that 60% of his patients showed only 'mild deterioration', that is, had preserved the ability to pursue an occupation.

Whereas, therefore, I accept that significant numbers of patients with schizophrenia can remain symptom-free and that others lead reasonably productive lives, it is still the case that the majority will experience a degree of impairment of function

and many will suffer frank relapses of their positive symptoms or chronic levels of such symptoms.

Psychiatrists should strive to achieve that those diagnosed with schizophrenia are treated so that they become as free as possible of symptoms (including adverse effects of treatment) and that they, their families and carers have as good as possible an understanding of the nature and behaviour of the illness, so that they can make effective informed decisions about their future healthcare. True empowerment requires the individual to have the best information available and the fullest command of their intellectual abilities in order to reach considered decisions based on that information.

The experience of psychosis is traumatic and bewildering. The course of the illness is unpredictable and frequently fluctuating. Those who have experienced it should have ongoing advice, support and treatment to cope with this.

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- 2 Warner R. Does the scientific evidence support the recovery model? *Psychiatrist* 2010; **34**: 3–5.
- 3 General Medical Council. *Good Medical Practice*. GMC, 2006.
- 4 Bleuler E. *Dementia Praecox or the Group of Schizophrenias*. International University Press, 1950.

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## 'Patients' – preferred and practical?

Simmons *et al*<sup>1</sup> suggest that the majority of recipients of mental health services do appear on the whole to prefer the term patient, according at least to evidence from studies in London and Hertfordshire.

Although our guidelines prefer other terms, the American Psychiatric Association practice guidelines<sup>2</sup> exclusively use the collective patients to refer to individuals receiving psychiatric care. Similarly, the Canadian Psychiatric Association clinical practice guidelines (such as those for treatment of depressive disorders<sup>3</sup>) refer solely to patients. Although other terminology is in use and under debate, patients is possibly also preferred by Canadian recipients.<sup>4</sup> Cultural differences in attitudes to psychiatry and the organisation of healthcare services may account for the difference in terminology.

I wonder to what extent individuals receiving mental health services who are or have been detained formally under the Mental Health Act in the UK would consider themselves clients or service users. It is possible that those that have been detained (currently or in the past) may prefer the term patient (because they were admitted to a hospital), whereas those individuals who receive or have received treatment primarily in the community may have a different perspective of mental health services and prefer terminology with fewer associations with perceived paternalism.

A final consideration might be to what extent the incorporation of the terms client and service user into psychiatric parlance, if fully embraced, would be practical when taken to its logical conclusions – should we, for example, be

referring to 'in-clients' and 'out-clients' rather than in-patients and out-patients?

- 1 Simmons P, Hawley CJ, Gale TM, Sivakumaran T. Service user, patient, client, user or survivor: describing recipients of mental health services. *Psychiatrist* 2010; **34**: 20–3.
- 2 American Psychiatric Association. *Psychiatric Practice Guidelines*. APA ([http://www.psych.org/MainMenu/PsychiatricPractice/PracticeGuidelines\\_1.aspx](http://www.psych.org/MainMenu/PsychiatricPractice/PracticeGuidelines_1.aspx)).
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- 4 Sharma V, Whitney D, Kazarian SS, Manchanda R. Preferred terms for users of mental health services among service providers and recipients. *Psychiatr Serv* 2000; **51**: 203–9.

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## Service user carries a stigma

The term service user is one I employ reluctantly. In my opinion it carries a stigma and leads to denial of the patients' rights to have effective treatment. I think using the term is part of the movement to 'socialise' psychiatry and we need to insist that psychiatric illnesses are similar to any other illnesses, and those who suffer from them are patients. Do cardiologists refer to patients with myocardial infarctions as service users?

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## Ancient origins of the term patient

The word patient originally meant 'one who suffers'. The English noun comes from the Latin word *patiens*, the present participle of the verb *patior* meaning 'I am suffering'.

The word patient has been used for hundreds of years but it is only recently that non-medical and non-nursing disciplines have started to advocate the use of words client or service user.

At the heart of this lies the social model of care which intends to demedicalise the management of illnesses so that patients may move away from the medical model, which is perceived to include 'labels' and 'pharmacological treatments'.

By calling people patients I do not believe that we are making them sicker or denying them their rights, as has been popularised; on the contrary, we are helping to continue the unique doctor-patient relationship. This relationship has evolved over centuries and is built on mutual respect, knowledge, trust, shared values and openness.

Patients themselves like to be called patients as evidenced in a few recent studies. Likewise, when I am ill, I would rather be called a patient and not a client, which has some distasteful connotations to it. Also, I would like to be called a doctor rather than a provider, teacher, clinician or advisor, even though my role might vary from patient to patient.

I find it hard to understand how by retaining the word patient one cannot achieve a secure base, supportive

relationships, hope and empowerment, and aim to be a productive member of the community.

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### Doctor, I presume?

I routinely ask my new patients how they want me to address them and *vice versa*.<sup>1</sup> I have not kept records so my data are approximate.

Nearly all my patients want me to call them by their first name. About a third to a half say they wish to call me by my first name, although not all consistently do so; one expressed a preference to call me 'Doc'.

I routinely ask my new trainees the same questions. So far all have expressed a preference for me to call them by their first name, and about 95% wish to call me by my first name, usually doing so.

Mental health review tribunals usually ask patients how they wish to be addressed, but do not ask staff this nor indicate how they themselves wish to be addressed (I personally take my cue from patients' legal representatives and call them Sir or Ma'am). All patients I can remember have expressed a preference to be called by their first name; all tribunals I have attended address the professionals by title and surname, thus creating disparities.

It is now usual for consultant colleagues to call each other by their first names (when on talking terms!). However, I have

a consultant colleague who is younger than me (although now senior in medical management terms) who calls me by title and surname, although I have asked him to address me by forename; he considers that calling me by my forename would be disrespectful. I now rarely hear the surname alone, which used to be commonplace; a few colleagues have accepted abbreviations or other appellations.

I am aware that nursing colleagues mostly find it hard to call me by my first name, even when I have requested this, and some of them have commented on the difficulty they experience. I personally find it offensive to be routinely addressed in impersonal terms by a nurse I have worked closely with for over a year – this is usually Doctor but occasionally a random endearment such as 'sweetheart' that some nurses habitually use with patients and colleagues.

The situation is complicated by the third person. Nurses routinely call me Dr Dodwell to patients, even when I am on first-name terms with both nurse and patient in one-to-one situations, and I notice that patients pick up on this and call me Dr Dodwell in front of the nurse. This occurs even when I have explicitly asked the nurse not to use this form of address. When I am with patients, I often call medical colleagues – consultant and junior – by Dr plus surname, and do so inconsistently with colleagues.

1 Allen JC. Another greetings survey? (letter) *Psychiatrist* 2009; **34**: 36.

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