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.[1–3] 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[4] 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.[1] 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[1] and therefore we feel that our survey cannot be simply ignored because of the low response rate.

We agree with Menon *et al*[1] 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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doi: 10.1192/pb.34.3.114

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)[1,2] and the accompanying commentary[3] in which Femi Oyebode 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

https://doi.org/10.1192/pb.34.3.114a Published online by Cambridge University Press

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.

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doi: 10.1192/pb.34.3.114a

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’.[1] 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.[2] 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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doi: 10.1192/pb.34.3.115

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[1] 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

https://doi.org/10.1192/pb.34.3.114a Published online by Cambridge University Press