The Future of Psychiatric Education: An International Perspective

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It is with great pleasure that we introduce this collection of *Academic Psychiatry*, which contains three key papers providing an international perspective on the future of psychiatric education (1–3). Authors well placed within the field of psychiatric education discuss current issues facing psychiatric educators in the United States, Canada, and the United Kingdom. In our commentary, we highlight many of the main issues discussed in these papers.

### Competence-Based Outcomes

One of the most significant changes identified across all papers is the shift from an apprenticeship, time-based model to competence-based outcomes in medical education and residency training. In the late 1990s, David Leach, Executive Director of the Accreditation Council for Graduate Medical Education (ACGME) introduced a competency model of instruction in postgraduate education that included six Core Competency domains: patient care, medical knowledge, professionalism, interpersonal and communication skills, practice-based learning and improvement, and systems-based practices (4). The next accreditation rendition is developing the six core competencies into numerous core milestones. This milestone-oriented model is a new system, designed to help us realize the promises of the outcome approach to psychiatric training.

In Canada, the CanMeds physician competency framework was developed to better respond to the needs expressed by society, specific populations, and the individual patient. This innovative model identifies competencies in seven roles: communicator, collaborator, health advocate, manager, scholar, and professional, with an emphasis on serving society, and patients within the context of populations (2). Key competencies are discussed in the Royal College documents at different levels: introductory knowledge, working knowledge, and proficiency. In Canada, these requirements are reached within a 5-year residency system, although the first year of training focuses on other medical specialties (2).

Similar shifts toward outcomes occurred in the United Kingdom, with greater attention being given to assessment of specific competencies throughout training. The path to attaining specialty status as a psychiatrist is clearly different in the United Kingdom. After 5 years of medical school, trainees enter a 2-year Foundation Training Program. After completion of this training, an additional 6 years is required to obtain psychiatry specialty status. Carney and Bhugra describe specific requirements in the U.K., where trainees must undergo an Annual Review of Competence Progression (ARCP) to determine level of competency and fitness, before moving to the next level (3).

The United States, Canada, and the United Kingdom have become more specific regarding outcomes of training. In Canada, the CanMeds Roles have outlined specific outcomes for each level of competency, so the trainee is evaluated according to these guidelines (2). These changes have demanded changes in assessment methods that require more observation, accurate assessments, and a focus on ongoing formative assessment, rather than high-end, summative evaluation. Starting in 2014, United States psychiatry programs will be required to demonstrate resident proficiency in the attainment of numerous milestones, repetitively measured as training progresses. Residents will also be required to pass (show competency) in three Clinical Skills Evaluations (CSE) physician–patient examinations. Clinical Skills Evaluations focus on competency in 1) the physician–patient relationship; 2) the psychiatric interview, including...
the mental status examination; and 3) case presentation (1). Similar competencies have also been outlined for trainees in the U.K., which, in addition to clinical competencies similar to the above, include participation in research, journal club attendance, and other academic activities (3).

End-of-Training Examination

The last decade has also witnessed changes to the end-of-training examination, primarily in North America. This shift began initially in Canada, with the Royal College of Physician and Surgeons of Canada. Saperson notes a move away from the high-stakes, long case evaluation, to multiple OSCE stations (Objective Structured Clinical Examinations) (2). This shift in assessment was made to deal with the low reliability and validity of the high-stakes, long case, summative assessment method. The current practice of multiple shorter assessments with multiple examiners, using the OSCE format, has been incorporated to provide a more reliable and valid assessment in a high-stakes examination. As Saperson notes, many examiners objected to the change in this format because it was felt that the long case provided more information about the candidate’s clinical skills with an actual patient. Despite these objections, the Royal College proceeded with the changes, which have now been in place for many years (2). Bernstein also discusses changes to the end-of-training exam in the United States (1). The new board-certification process requires that each psychiatric residency-training program must administer and document successful resident completion of three Clinical Skills Evaluations (CSE). Upon graduation, residents apply for American Board of Psychiatry and Neurology (ABPN) certification. Initial resident applications for ABPN certification must be made within 7 years of graduation.

After 10 years of ABPN certification, board certification has to be renewed in a new process called Maintenance Of Certifications (MOC). MOC requirements include 1) self-assessment, 24 Continuing Medical Education (CME) credits every 3 years; 2) 30 CME credits/year, totaling 300 CMEs over 10 years; 3) a written/cognitive examination; and 4) Performance in Practice activities, which includes a clinical practice improvement project and standardized feedback from patients and peers over 10 years.

Changes to Residency Training Evaluation

Given the shift in the RCPSC end-of-training exam, programs are now responsible for assessing a trainee’s ability to carry out a psychiatric interview (long case) in the training program. In Canada, programs vary with respect to how this is carried out. One method, known as the STACER (Standard Assessment of a Clinical Encounter Report), places responsibility on the program with the supervisor, who carries out a formal assessment with a resident conducting a 50-minute clinical interview with a patient with an accompanying presentation (2). The emphasis of the assessment of the long case to now be carried out in residency training leads to more formative assessments conducted throughout the training program.

In the United Kingdom, assessment has also been emphasized in training. Carney and Bhugra discuss the importance of resident logs, portfolios, and other methods that track the resident’s assessments across training (3). This has shifted the burden of assessment to the supervisors in core training and has put increasing pressure on training directors to ensure observation measures are carried out. As discussed above, in the U.K. residents must complete the Annual Review of Competence Progression before they can proceed to the next level.

Specialty Training

The goals of psychiatric training have been clearly outlined by the United States, Canada, and the United Kingdom with the end-point of psychiatric residency being the graduation of the competent general psychiatrist. The RCPSC (Canada) emphasizes graduating the “sophisticated generalist,” the Royal College of Psychiatry (U.K.) emphasizing the generalist, and the Accreditation Council for Graduate Medical Education (U.S.) focusing on the attainment of milestones for the general psychiatrist. All three papers discuss the emergence of “specialty training” in psychiatry in several areas. Psychiatrists in the United States are able to specialize with additional fellowship training in Child-Adolescent, Addictions, Forensic, Geriatric, Psychosomatic, and Pain Medicine (1). A Sleep fellowship may also be developed as an additional psychiatric subspecialty. Recent trends in U.S. fellowships indicate that fewer than half of U.S. psychiatric residents pursue any fellowships (5). There has been the greatest decline in residents pursuing geriatric and addiction fellowships, whereas child and adolescent fellowships remain the most popular. The future of all U.S. psychiatric fellowships is not clear and will likely depend on the evolution of the new U.S. healthcare system.

In Canada, specialty training is offered in Child and Adolescent, Forensic, and Geriatric psychiatry (2). In the