Correspondence

Acute assessments in psychiatry

As a core trainee in psychiatry, I feel the issue of trainees working out of hours is vitally important.

With changes to rotas as described by Conn & Husain,[1] trainees find themselves not having to do acute crisis assessments and instead, nurse-led assessments are becoming more common. These factors have a huge impact on psychiatry as a specialty. Junior doctors on certain rotas are not involved in the decision-making process for admission and are simply used as clerking machines responsible for completing paperwork and a physical examination once the patient is admitted. No other specialty works in this way; all acute non-psychiatric referrals are seen by doctors and a full assessment is carried out, including discussion with senior medical personnel, before the management plan is finalised.

I feel that patients needing acute psychiatric assessments usually present with multiple problems and comorbidities which require the doctor's input to ensure a holistic approach and that organic factors are taken into account. During my first core training year, the experience I got with acute assessments helped considerably to develop my skills in assessing and managing risk and dealing with acute presentations.

The image of psychiatry among numerous medical students whom I have been involved in teaching, and that revealed in recent surveys, is that 'psychiatry is an easy option'.[2] I feel it is time that psychiatry stands up and shows what it has to offer. This needs trainees to get involved in assessments and take responsibility to ensure that psychiatry has a future.

1 Conn R, Husain M. Trainees want to work out of hours! *Psychiatrist* 2013; **37**: 117.

2 Archdall C, Atapattu T, Anderson E. Qualitative study of medical students' experiences of a psychiatric attachment. *Psychiatrist* 2013; **37**: 21–4.

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A message to psychiatry trainees: keep your finger on the pulse

In light of the recent Royal College of Psychiatrists' report on achieving parity between mental and physical health,[1] the paper by Yadav & Vidyarthi[2] came as a timely illustration of the need for trainees to take responsibility for their continuing professional development and the role of the College.

Patients put their faith in doctors of all specialties to look after them. In an acute situation they implicitly trust us to be able to perform investigations, interpret the results correctly, and act appropriately to instigate swift and appropriate management. In the UK, the overarching duties of a doctor are laid out by the General Medical Council.[3] One such duty is to 'keep your professional knowledge and skills up to date, recognise and work within the limits of your competence, and work with colleagues in a way that best serves the patient's interest'. This is echoed in the Royal College of Psychiatrists' *Good Psychiatric Practice*. We hope most trainees would agree with Craddock *et al*[4] who believe that psychiatrists are 'first and foremost highly trained doctors'.

Admittedly, the specialty suffers from esteem issues, but if we want to be respected as doctors we must commit to continued professional development to improve the care for our patients. *The NHS Outcomes Framework* hopes to improve professionals' attitudes towards patients. Are we not discriminating against our own patients if we fail to take responsibility for keeping our clinical skills up to date?

We reviewed the CANMEDS competencies framework, which is used by a number of varied specialties both in the UK and abroad. 'Medical expert' is a key domain. This is not to suggest a trainee must be 'expert' in, say, reading electrocardiogram (ECG) results, but rather that they should be able to integrate knowledge, clinical skills and professional behaviours in order to provide excellent care for their patients. The College has carefully mapped the CANMEDS competencies on to its curriculum for core trainees. However, we caution that there is not a clear expectation or way of assessing trainees' medical skills.

In contrast, the core curriculum for core medical trainees comprehensively addresses the knowledge, skills and behaviours required to manage psychiatric emergencies. As well as acute medical presentations, core medical trainees must also demonstrate competencies in the following presentations: suicidal ideation, aggressive/disturbed behaviour, acute confusion/delirium, and alcohol and substance dependence. Furthermore, there is clarification of what they should demonstrate. For example, every core medical trainee should 'be competent in predicting and preventing aggressive and disturbed behaviour, using safe physical intervention and tranquillisation [. . .] and investigating appropriately and liaising with the mental health team' (p. 77).[5]

Psychiatry trainees frequently complete a workplace-based assessment on electroconvulsive therapy. Perhaps performing an ECG or physical examination and interpreting the findings may be sensible competencies. It is heartening that the Royal College of Psychiatrists seem to recognise the need for trainees to maintain essential medical knowledge. There are some very good College CPD Online modules such as 'Taking a general medical history in psychiatry' and the appositely named 'Don't shrink from ECG'. We welcome the planned expansion of the free CPD modules and anticipate there may be more on medical themes. The December 2012 diet of the MRCPsych Paper 1 featured a question on ECG interpretation. Some trainees found this controversial, but others would regard this as a pass/fail question.

We therefore argue that the current psychiatry core curriculum could better address the medical competencies required in sufficient detail to motivate all trainees to attain and maintain their skills. Let's work with and learn from our medical colleagues.

1 Royal College of Psychiatrists. *Whole-Person Care: From Rhetoric to Reality. Achieving Parity Between Mental and Physical Health* (Occasional Paper OP88). Royal College of Psychiatrists, 2013.

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