Training Across Boundaries: a new way to promote inter-professional training

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Abstract

There have been substantial changes in postgraduate medical training in the UK in the last two decades. At present when trainees progress beyond medical school and Foundation training, they have limited opportunities to train in other disciplines or to learn more about specialties outside their chosen field.

This paper describes a new initiative called Training Across Boundaries, targeting core psychiatry trainees, providing opportunities for psychiatry trainees to have placements in other specialties and evaluated this process. Feedback from structured interviews with the participants is presented.

The pilot seems to have opened up opportunities for cooperation and learning between doctors from different disciplines. The authors suggest that we need to think more about bringing training in psychiatry, primary care and medical specialities closer, to improve the breadth and quality of training and patient care.

Background

The past 20 years have seen significant developments in medical education in the UK and elsewhere (1). The Royal College of Psychiatrists developed a new Core and General Curriculum in 2008 which moved away from the traditional apprenticeship model previously prevalent in medical training, towards more structured and systematic training based on the development of competence in defined areas of practice. The new training programmes each have defined curricula, which link to some degree to assessment and quality assurance processes. Training has therefore become increasingly outcome-based and defined by the curriculum and competences required in each specialty. Specialty years one to three focus predominantly on general and old age psychiatry, but must include exposure to developmental psychiatry. Arguably the focus on achieving the core competencies in psychiatry has led to a reduction in opportunities to develop other training opportunities, which was possible in previous training models.

Some psychiatrists have suggested that developments in the workplace have had more influence on training, than academic developments and concern has been expressed that advances in the interfaces between psychiatry, neurology, geriatrics, cardiology, immunology and endocrinology have not sufficiently been addressed in clinical placements (2, 3, and 4). Various authors have recommended that to train psychiatrists for the future, it will be helpful to provide opportunities for exposure to different medical specialties, including general practice. Table 1 summarises issues described in a recent article (5) as particular reasons to gain experience in medical specialities during psychiatry training:

Table 1 here

Training in psychiatry in other developed Countries such as the USA, Canada and most parts of Europe typically has a more medically inclusive focus and the UK model appears narrower in this respect. Psychiatric trainees in the United States are required to spend 12.5% of their time in residency on rotations devoted exclusively to

non-psychiatric medicine(5). In adult psychiatry training in Europe, nine Countries require a placement in neurology, six in internal medicine and others routinely promote access to medical specialties (15). The lack of exposure in UK schemes has been lamented (2, 3), with proposals that placements in medical specialties such as neurology, cardiology, endocrinology and geriatric medicine should be an integral part of higher professional training.

We could not find any example in the UK where there has been a substantial pilot project looking at the development of this type of training arrangement.

Training across boundaries project

Training Across Boundaries (TAB) started in July 2012, aiming to develop training links between core psychiatry and medical specialties /primary care. The project encouraged the use of up to six sessions in a medical speciality/primary care during a 6 month core psychiatry placement and evaluated the benefits gained from this experience.

Before commencing the project, a protocol was developed and information was shared with the Directors of Medical Education in the two participating Mental Health Trusts, the Heads of School of medicine and general practice and senior Deanery colleagues. As direct patient care was not involved, we were advised that formal approval from a research ethics committee was not required.

Information about the project was sent to all core trainees of years two and three trainees and their educational supervisors in Avon Wiltshire Partnership Trust and 2Gether NHS Foundation Trust. Trainers were encouraged to identify possible learning opportunities in their local area for the core trainees. The project team offered help with contacting colleagues in primary care and medicine if needed .The team also compiled a list of possible placements and this information was sent to the core trainees, who were also encouraged to consider their own needs and preferences, through educational supervision.

Core trainees chose placements in primary care/medical specialities which were related to the post they were in. The project was rolled out for the core trainees in year 2 and 3 from February to July 2013. During this period the trainees were encouraged to maintain a reflective log of their experience in their portfolio, discuss their experience in supervision and ideally complete a workplace based assessment in the TAB placement.

Results

14 of 22 core trainees started a TAB placement in February 2013. Two trainees had to drop out due to personal reasons. Of the 8 trainees who did not undertake a TAB placement, five trainees expressed interest in participating in the programme but were unable to do in the time period because of taking exams, or other commitments.

Among participating trainees, the number of sessions trainees spent in the TAB placement ranged from 3 to 7 sessions, mean 4.2 sessions.

Twelve trainees completed a TAB placement in the period February 2013 to August 2013. Placements included neurology (two), primary care (three), medical gastroenterology (two), diabetes and endocrinology (two), emergency medicine (one) and paediatrics (two). Some trainees in year three chose specialities which were related to their plans for advanced training.

Feedback from the core trainees

Feedback was obtained from all the participants by means of structured interviews administered by SA and RM. The core trainees reported that the administration of the Training across boundaries project was effective. All the trainees reported that they were given sufficient information about the project and the placements before they started and they were involved in choosing their placement. All the trainees were well supported in organising the placement to suit their individual training needs. They were able to get advice and support as necessary from their educational supervisor and the project team during the course of their placement. They welcomed the flexibility around organising the placement to suit their individual needs.

Four trainees were able to complete a workplace based assessment during the TAB placement and described it as a useful learning experience.

Trainees Feedback from individual placements

Primary care

•Valued seeing how GP's coped with assessing mental health problems in very limited time and reflected on the differences from a typical psychiatric assessment.
•Useful to see the different range of mental illness presenting in primary mental health services, in particular mood and anxiety disorders which were of insufficient severity to be referred to secondary care.
•Reported interest in developing more contact with GPs, potentially through shared teaching experiences.
•Would like to have had more time for case discussions with the GP trainer.
•Be able to actively do assessments in primary care rather than just observing.

Neurology

•Gained a better understanding of typical conditions seen in neurology setting.
•Having a better awareness of the close links between psychiatry and neurology.
•Hoping to develop better working relationships with neurologists in the future.
•Opportunities to see many patients assessed for movement disorders which are common in psychiatry valuable.

•Many patients with psychiatric problems seen by neurologists in the first instance and liaison between the two specialties seemed quite crucial.
•Good opportunity to revise neurological examination technique.
•Appreciated the opportunity to examine patients under the supervision of a neurologist

Endocrinology

•Valued the experience in endocrinology as most common endocrine disorders were commonly encountered in psychiatry.
•Felt more confident about when to refer to a specialist.
•Helped to foster better working relationships with medical colleagues.
•Placement emphasised the need for better collaboration with medical colleagues in managing people with long term conditions.

Primary care

•Interesting experience to compare approaches to a problem from a paediatric setting and a CAMHS setting.
•Valued the joint working experience.
•Gaining a better understanding of the interface between child psychiatry and paediatrics.

The trainees reported a range of more general benefits from participating in the TAB programme, as in Table 2:

Table 2 here

Trainees also reported some challenges in their participation in the TAB programme. Core trainees in year 3 reported that they had many other commitments, including exams, psychotherapy, applying for advanced training and some suggested that trainees in years 1 and 2 may benefit most from this opportunity. Two trainees suggested that TAB may work well in the advanced training years as clinical special interest sessions, potentially over a longer period of time.

While they were doing the placement core trainees reported lot of interest from trainers and trainees in primary care and medical specialities about spending time in psychiatry and that we should think about offering similar placements in psychiatry to trainees in other specialties. All the trainees who completed the programme reported a positive experience and stated that they would highly recommend it to other trainees.

Discussion

The TAB project seems to have broadly achieved its aims, in a limited first year of activity. The pilot seems to have created opportunities for collaboration between doctors from different disciplines and there seems to have been substantial learning

about the different perspectives and priorities which govern specialist practice in the different specialist teams. By its design the project has explicitly promoted inter disciplinary training and working and the feedback has suggested that a greater interest and confidence engendered among the trainees who took part may develop this further.

We feel the results of this project show us that we need to think more about the potential value of bringing training in psychiatry, primary care and medical specialities closer. However the very nature of the current educational and training systems, with rigid specializations, departmental isolationism, emphasis on parallel care, and competition between the research and service missions can become substantial barriers to integrative learning and collaborative practice (16). Although it seems obvious that many patients' needs are interdisciplinary and improved healthcare needs to be an interdisciplinary effort, we often see a cost-ineffective, over-specialized, fragmented and at times rather dehumanized health care delivery system (16). The new generation of trainees may be well placed to challenge traditional, 'silo-based' thinking which may get in the way of good patient care.

There are a number of overlapping competency requirements in the curriculum for psychiatry and medical specialities which provide great opportunities for more integrated training and teaching. In particular leadership and communication skills offer opportunities for shared learning and the experience of TAB has helped trainees to see many of the commonalities of practice but also the cultural differences which operate in different parts of the health service. An understanding of this is likely to help to develop high level skills of negotiation, liaison and communication and ultimately more effective working across any 'boundary' encountered.

This initiative may have been timely, coming as it does at the time of the Shape of Training Review (17), which seems likely to result in greater generic training as a common stem for specialism, to be built on following achievement of the generic core through specialist exposure, the development of specialist expertise and credentialing of this, over time. The Shape of Training Review highlights the need to re-think current arrangements for postgraduate medical education and training and continuing professional development at all levels within the medical workforce (17).

The TAB scheme was optional but we were interested that some trainees (in fact over half of those who participated in this programme) spontaneously suggested that given the potential benefits from having such placements during the core training, they would be happy for such placements to become a standard, required part of their core training (especially neurology in the first year of psychiatry training). Reflection on the benefits from the programme has led a number of senior psychiatrists involved to consider whether they may undertake elements of a TAB programme, with (or without) their trainee colleagues, recognising that skill deficits in medicine and other fields inevitably become more greater and more problematic over a lengthy career.

Future plans

Many trainees have expressed an interest in continuing to do TAB placements within their core programmes .We are creating a database of trainers in medical specialties and primary care in Bristol and Gloucester who have offered placements, which will be available to core trainees and trainers .Trainees can opt to do a placement with support from their educational supervisor . We already have a system in place to offer taster days for Foundation Trainees interested in psychiatry and are looking to explore the possibility of offering similar placements in psychiatry to trainees in medical specialities and in primary care.

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Table 1

Reasons for psychiatrists to gain experience in medical specialties, after Wright (2009).

- There is a high rate of co morbid medical illnesses in patients with psychiatric disorders and markedly increased mortality (6). The failure of health care systems to adequately detect and address these conditions has been documented (6, 7). Improved detection of medical illness in psychiatric patients could lead to more timely treatment and decrease health care costs.
- An understanding of the multiple ways mental illness may present as somatic/physical disorder is seen as an essential element of being a competent psychiatrist (8,9), but relatively little attention is paid to this topic in training.
- Medical complications of psychiatric illnesses and treatments (e.g., alcoholic cirrhosis, metabolic syndrome related to atypical antipsychotic treatment) are common and lead to serious long term morbidity and mortality (9)
- Improved understanding of medicine among psychiatrists could benefit our profession. Psychiatrists need to be able to communicate effectively with colleagues in other specialties and to understand their clinical and educational needs (10).
- Problems of recruitment into UK psychiatry have been a concern for many years (3, 4 and 11). A number of factors, including a perception that psychiatrists do not use their hard-earned medical knowledge and skills, may dissuade some Foundation trainees from entering psychiatry (12, 13 and 14).

Table 2

General benefits from the TAB programme

- Learning about the importance of better working relationships with colleagues in medical specialities and primary care
- Understanding how teams function in medical settings/primary care.
- Thinking about the organic differential diagnosis in a more thorough and structured way.
- Bridging the gap between physical and mental health
- Greater confidence in managing medical comorbidity and knowing when to refer to a specialist.