How useful are workplace based assessments in old age psychiatry?

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The typical patient?
A new admission arrived on the ward, a 69 year old man called Stephen. He was brought in after a concerned GP noticed that he had not attended the practice for several months and had not collected recent prescriptions. Stephen was found to be living in squalid conditions, had lost over 10% of his body weight and no food was found in the fridge.

Stephen was initially seen in the accident and emergency department where he was found to be dehydrated and hypothyroid. He spent 1 day being rehydrated and an infective source was ruled out before being transferred to the psychiatric ward where he exhibited challenging and aggressive behaviours, appeared to be responding to hallucinations and was disoriented in time, place and person.

The GP stated that a few months ago Stephen was fully independent and lived alone. He had a history of ischaemic heart disease, hypertension and hypothyroidism and a family history of depression. The GP also stated that Stephen only had one daughter, from whom he was estranged after a family rift, and he has few close friends. The ward nurses were keen for some sedation to be given for his challenging behaviours. Shortly after that, the daughter arrived on the ward demanding to know what had happened to her father.

This vignette at first glance looks highly complex. The doctor is dealing with a patient with complex medical and psychiatric problems, a long list of differential diagnoses, social issues, risk, concerns and family and confidentiality issues all rolled into one clinical scenario. Yet such a case can be quite typical on an older adults psychiatry ward and exemplifies the skills needed by a clinician in this field.

Trainee assessment of the complex patient
Being able to take into account multiple clinical problems and formulating a management plan that keeps the patient and others safe, respects confidentiality and helps narrow the differentials, as well as providing symptomatic relief, is a crucial skill set to acquire for the trainee in old age psychiatry. Current practice in the UK training system would suggest using a ‘Workplace Based Assessment’ (WPBA), supervised by a consultant, to assess performance. A mini-CEX (Mini Clinical Evaluation Exercise – also known as Mini Assessment of Clinical Expertise (mini-ACE)) would allow the consultant to watch the trainee taking the history and performing the examination. Or, the CBD (Case Based Discussion) would allow the trainee to sit down with the consultant after the clinical encounter and discuss the management plan and documentation. It seems that, on the surface at least, the WPBAs provide a perfect framework to assess trainee competence and identify a failing trainee. However, when one looks at the situation on the ground, taking into account the availability of time and other pragmatic factors, there is some evidence to suggest that WPBAs are not entirely fit for their purpose and that maybe another approach should be taken.
Problems with WPBAs
WPBAs were introduced in the UK after the General Medical Council’s introduction of Modernising Medical Career’s (MMC) in 2005. MMC stated that assessment of doctors should be ‘competency based’ and WPBAs offered a way of standardised and reproducible assessments based on clinical competencies. Whilst WPBAs seem an excellent way of meeting MMCs criteria on paper, some evidence suggests that the reality is different.

Wilkinson et al.² conducted a study of 655 junior doctors undertaking WPBAs in the UK and found that for the mini-CEX to be a reliable instrument, it must be ‘observed by at least 8 different assessors observing at least 2 encounters each for it to be statistically reliable.’ The Royal College of Psychiatrists asks for only 4 mini-CExs / mini-ACEs to be performed per year and makes no stipulations on how many different people should assess. Even if a studious trainee were to meet Wilkinson’s criteria for reliability, this would most likely occur at the end of Core Training, making it difficult for this WPBA to identify a struggling junior in a timely manner.

So, if a trainee puts in a good performance in a mini-CEX in the case of Stephen, it might be because the trainee is competent, but equally it could be because the assessor is lenient or the trainee has a lot of knowledge in one area but gaps in another or a variety of other reasons.

Perhaps a Multi Source Feedback (MSF, also known as 360 degree feedback) might be a better way of assessing the competency of a trainee and to identify a failing one? It seems reasonable that one assessment from a wide variety of peers, over a long period of time in multiple domains offers a more reliable assessment of a trainee’s performance.

Wilkinson et al.² suggest that ‘feedback from 12 assessors is necessary to achieve reliability in the MSF’. This is a much more achievable goal. Core Medical Training and the Foundation Programme in the UK ask for 12 assessors for a MSF. However, Core Psychiatry Training currently only asks for 8. I believe that there are a set of important respondents that are completely left out: the patients! A great proportion of the MSF questions ask peers about their opinions on the trainee’s clinical and communication skills with patients. This is third hand information; surely collecting some information from the patients themselves would provide a deeper level of insight into these skills.

I think that this is especially important in psychiatry where the doctor / patient relationship is perhaps more crucial to treatment success than in any other branch of medicine. Having said that, the cohort of patients seen in older adult psychiatry wards presents more difficulties in obtaining reliable and valid feedback than in most other disciplines. For example, patients with significant cognitive impairment may not be able to complete the forms. MSF tend to be online based and this may cause difficulties in completion for older patients. Although only a minority of older adult inpatients on psychiatric wards tend to be detained under the Mental Health Act, this group of individuals tend to have a negative view of their stay in hospital and may project these feelings in the MSF.³

The MSF probably has the best evidence of being an accurate, valid and reliable source of gathering information about trainee performance. Making the MSF truly a 360 degree feedback by including patients’ and relatives’ feedback should improve what is already a highly useful assessment. Such practice is already common in countries such as Canada and also forms a part of UK consultants’ revalidation requirements. To overcome the specific difficulties in older age psychiatric patients, perhaps the clinical supervisor could select
which patients should provide feedback for the MSF. This would help eliminate problems due
to cognitive impairment or undue negative bias and would also prevent the trainee from
cherry picking their favourite patients. As we shall see, this can also be a pitfall of WPBAs.

**Hiding the truth?**
OK, so WPBAs might not be the most reliable way of assessing the trainee but reliability is
difficult to achieve in the real world of clinical psychiatry. What is more important is that the
WPBAs assess the trainee in a real life situation, potentially making it a much more useful
assessment tool than a multiple choice question exam.

However, it may also be the case that decent scoring WPBAs from a trainee might lull the
clinical supervisor into a false sense of security about their trainee’s clinical competence. A
key problem with the WPBAs is that the trainee gets to pick the clinical scenario and who
they want to assess them. This inevitably leads to trainees picking clinical situations with
which they are more comfortable, and selecting peers who are more likely to give a positive
assessment of them. So if the trainee in Stephen’s case did not feel competent in handling
this scenario, he could avoid being assessed in it and instead select a patient he felt more
comfortable with.

Mitchell et al found that trainees in difficulty were more likely (Odds Ratio (OR): 4.0 (95%
CI: 0.75-21.26)) to pick easy scenarios for the mini-CEX than their colleagues who were not
deemed to be failing. In addition, trainees in difficulty were less likely (OR 0.62 (95% CI:
0.05-7.33)) to choose nurses to assess them in MSFs than their counterparts. Other studies
have shown that nurses, compared to other team members, are the most proficient at
identifying a failing trainee through the MSF method.

Perhaps allowing supervisors, instead of trainees, to have control over what is assessed and
by whom, a clearer picture of the trainees strengths and difficulties will emerge. This is
especially important for the trainee in difficulty.

**What do the assessors think?**
Whilst there are a lot of positive comments about WPBAs from clinicians at all levels, there
are also some concerning comments and statistics that cast further doubt on the usefulness of
the WPBA.

Wilkinson et al asked assessors if they thought that the WPBAs ‘provided any useful
information about the trainee that they previously did not know’. Only 40% thought that this
was the case for the mini-CEX and 25% for the DOPS (Direct Observation of Practical
Skills). Bindal et al conducted some qualitative research in this matter with common themes
occurring such as ‘WPBAs lower the goalposts and make juniors less willing to try at
procedures they are not comfortable with’ and that ‘bad doctors can actually look better if
they perform assessments less frequently.’

**What is the answer?**
Clearly there are problems with WPBAs but they still offer a practicable means of assessing
trainees in a wide variety of ways. I don’t think that they should be scrapped but they could
be improved upon. Educational and clinical supervisors should have more of a say in who
assesses the trainees and what they are assessed in. Patient opinions and feedback should also
be included in all of the assessments conducted by the trainee.
There is a tendency for assessors to rely on the WPBAs as the primary piece of evidence that a trainee is doing well but they are not good enough tools to be used for this purpose. They should form a supporting part of the total assessment only. The importance of the clinical and educational supervisor’s judgement of general performance over a placement should be given more weight in the annual assessment of clinical competencies. In psychiatry in the UK, currently this is overlooked in place of the WPBAs. Perhaps a detailed report written by the educational supervisor at the end of the placement, including feedback from peers and patients would be a useful accompaniment to the WPBAs.

Trainees in old age psychiatry will often work in teams where there are only a small number of consultants available to perform WPBAs. This could be used as an opportunity to develop and be assessed in a variety of skills by other colleagues with specialist knowledge. For example, a trainee could be required for perform a cognitive assessment on a patient under observation by a neuropsychologist or to give advice regarding administration and monitoring of lithium whilst being assessed by a pharmacist.

Having feedback from patients will provide useful information for a 360 degree MSF feedback. However, in old age psychiatry, educational supervisors could ensure that some of the feedback includes carers’ opinions, especially when significant issues with cognitive impairment have been identified. Educational supervisors could also stipulate that WPBAs should cover a wide variety of both functional and organic difficulties. This would help alleviate the problem of the trainee potentially avoiding scenarios with which they are uncomfortable as well as providing them with new learning opportunities. For example, many old age psychiatry training jobs only include inpatient work with little or no opportunity for outpatient or community work. By asking that WPBAs cover these areas, supervisors will give their trainees a broader clinical experience in the specialty and may also give the trainee a more positive experience of their placement.

The discipline of old age psychiatry involves looking after complex patients like Stephen as a routine part of the job, combined with an often busy clinical environment with minimal time for formal learning and assessment. Proper evaluation of the trainee is often equally complex and there will always be issues in balancing appropriate assessment of trainees with service provision. The key to success in this field is not to rely too heavily on one mode of assessment and to be aware of the numerous difficulties with ‘competency based assessment’.

References