Teaching and training

AUSTRALASIAN PSYCHIATRY

Australasian Psychiatry
2016, Vol 24(6) 615–619

DOI: 10.1177/1039856216671649
apy.sagepub.com
SAGE

When should I attempt my centrally administered summative assessments in the RANZCP competency-based training program?

Warren Kealy-Bateman Clinical Senior Lecturer, Graduate School of Medicine, University of Wollongong, Wollongong, NSW, and; Department of Psychiatry, Professor Marie Bashir Centre, Royal Prince Alfred Hospital, Camperdown, NSW, Australia

Beth Kotze Conjoint Associate Professor University of NSW, Adjunct Professor University of Technology Sydney, Sydney, NSW, and; Children's' Hospitals Network, Westmead, NSW, Australia

Lisa Lampe Senior Lecturer, Discipline of Psychiatry, Sydney Medical School, University of Sydney, Sydney, NSW, and; CADE Clinic, Department of Academic Psychiatry, Royal North Shore Hospital, St Leonards, NSW, Australia

Abstract

Objective: To provide information relevant to decision-making around the timing of attempting the centrally administered summative assessments in the Royal Australian and New Zealand College of Psychiatrists (RANZCP) 2012 Fellowship Program.

Methods: We consider the new Competency-Based Fellowship Program of the RANZCP and its underlying philosophy, the trainee trajectory within the program and the role of the supervisor. The relationship between workplace-based and external assessments is discussed. The timing of attempting centrally administered summative assessments is considered within the pedagogical framework of medical competencies development.

Results: Although successful completion of all the centrally administered summative assessments requires demonstration of a junior consultant standard of competency, the timing at which this standard will most commonly be achieved is likely to vary from assessment to assessment. There are disadvantages attendant upon prematurely attempting assessments, and trainees are advised to carefully consider the requirements of each assessment and match this against their current level of knowledge and skills.

Conclusions: Trainees and supervisors need to be clear about the competencies required for each of the external assessments and match this against the trainee's current competencies to assist in decision-making about the timing of assessments and planning for future learning.

Keywords: competency, medical education, specialist training, assessment, examinations

There has been a shift in the focus of medical education over the last few decades. The reliance on summative cross-sectional assessments that served as barriers to progression has been complemented by workplace based assessment and ongoing formative feedback for learners. This greater emphasis on competency based assessment and learning has been widely adopted by the Australian Medical Colleges, the Australian Medical Council, Health Workforce Australia and the Medical Deans of Australia.[1] At the international level competencies have been mapped to domains that capture and define the essence of a medical expert. The Royal Australian and New Zealand College of Psychiatrists (RANZCP) has chosen the CanMEDS framework from the Royal College of Physicians and Surgeons of Canada as their reference point for the development of a competency-based program with associated developmental descriptors and learning outcomes.[2] The RANZCP

Corresponding author:
Warren Kealy-Bateman, Graduate School of Medicine, University of Wollongong and Department of Psychiatry, Professor Marie Bashir Centre, Royal Prince Alfred Hospital, Camperdown, NSW, Australia.
Email: warren.kealybateman@gmail.com

embarked on the Competency-Based Fellowship Program (CBFP) in 2012 for new trainees,[3] and all trainees will transition to this program in 2016.

Across the five years of specialist training the RANZCP program has been divided into three stages of competency: basic (Stage One; usually one year full-time equivalent (FTE)), proficient (Stage Two; usually two years FTE) and advanced (Stage Three; usually two years FTE). In their term assessments trainees are given feedback about their current level of skill and knowledge, and how this compares to what will be required by the end of that stage. This enables trainee and supervisor to work together to plan appropriate learning activities that will assist the trainee to work towards achievement of the competencies required for progression to the next stage. Multiple workplace-based assessments (WBAs) provide timely, formative (not recorded as a pass or fail on the academic record) feedback for the learner, and inform supervisor decisions about whether trainees can be trusted to perform identified professional activities (entrustable professional activities, or EPAs) with only distant supervision. The EPAs are mapped to the required competencies that are part of the RANZCP training program. In order to progress through the stages of training, trainees must demonstrate that they have attained the required competencies, through achievement of required EPAs and satisfactory in term assessments (ITAs). A similar approach has been adopted across other speciality groups.[4,5] Importantly, decisions about whether a trainee has demonstrated the competencies required to progress to the next stage of training are made locally.

Summative, centrally administered assessments also occur and are recorded on the academic record, but do not form a barrier to progression. There are five landmarks with some flexibility of timing: four written assessments comprising a multiple choice-style (MCQ) examination, an essay-style examination, a psychotherapy case report (the psychotherapy written case (PWC)) and a scholarly project. There is one clinical assessment, the observed structured clinical examination (OSCE). In the new program all of the assessments have been set at the standard required of a junior consultant. This is the level of knowledge and/ or competency that a trainee is expected to demonstrate at the completion of training.

The RANZCP has both suggested and expected timing around attempting the centrally administered assessments (Table 1). It is evident from Table 1 that although the knowledge and skills required for successful completion of these assessments are at the junior consultant level, a number are scheduled to be attempted before this milestone is likely to be achieved. This can be explained by Miller's prism of clinical competence, or Miller's pyramid, an educational concept that hierarchically ranks the level of competence from novice to expert.[6] At the most basic level of trainee competence the focus is on knowledge of facts such as those that can be tested by MCQs. Much of this factual information forms the foundational knowledge essential for all levels of practice, from basic trainee to experienced Fellow, and hence a 'junior consultant' level of knowledge may be attained quite early in training. At intermediate levels of competence a learner is expected to be able to integrate and apply knowledge: this may be appropriately tested through the other written assessments. At the higher levels of competence the trainee is expected to be able to demonstrate their acquired skills and knowledge in realistic clinical settings, and a clinical examination is an appropriate means of testing when an externally assessed, summative assessment is desired. As examples, trainees are expected early in their training to acquire a level of factual knowledge about psychotropic medication that is equivalent to a junior consultant, and this can be tested via MCQs. At a later stage of training they will be required to apply this knowledge in a more complex context such as a simulated or real clinical situation, and this can be assessed via the essay-style examination, as a component of reference in the write up of psychodynamic treatment in the PWC or in a structured clinical examination.

From the trainee perspective

Different preparation and expectations are required for formative compared to summative assessments.

Workplace based assessments are extremely valuable opportunities for formative feedback. At times it may also challenge the ego to receive feedback that is contrary to a self-assessment, but it is a learning opportunity. It is not recorded on the academic record and can be approached with an attitude of: 'can try, can do, can fail at the task and can learn'. Evidence shows that learners prefer feedback which is fair and accurate, even if less glowing than desired.[7]

The observed clinical activity is a required formative assessment task each six months. It is an invaluable opportunity to learn from each term supervisor while developing this core competency expected of every clinician in psychiatry. For this reason some trainees choose to complete this task more than once each six months. It is important to bear in mind that the supervisor is required to judge the trainee's performance against the standard required at the *end of that stage of training*. It is therefore highly likely that a trainee in their first rotation of Stage 2, for example, will be unable to demonstrate the standard required at the *end* of Stage 2. For highly intelligent and motivated doctors who may have never had an unsatisfactory result, it is likely to be challenging to hear that the required standard has not yet been met, but as noted, it is an opportunity to identify the skills and knowledge required to progress to the required standard. It is also likely to be very difficult for supervisors to give feedback that a trainee has not yet demonstrated the required standard, but critical to the success of a program that relies so heavily on formative feedback to guide training and determine whether the

Table 1. The RANZCP Training Trajectory with suggested and expected timing (shaded)

INTENDED TO PROVIDE TRAINEE WITH A BASELINE AGAINST WHICH THEIR PROGRESS WILL BE MONITORED TO ENSURE A STEADY PROGRESSION

Expected Fellowship

	STAGE 1		STAGE 2				STAGE 3					
FTE MONTHS [*]:	**6**	**12**	**18**	**24**	**30**	**36**	**42**	**48**	**54**	**60**	**66**	**72**
ROTATION EPAs	ITA with associated OCA & 2 EPAs[†]	ITA with associated OCA & 2 EPAs	ITA with associated OCA & 2 EPAs	ITA with associated OCA & 2 EPAs	ITA with associated OCA & 2 EPAs	ITA with associated OCA & 2 EPAs	ITA with associated OCA & 2 EPAs	ITA with associated OCA & 2 EPAs	ITA with associated OCA & 2 EPAs	ITA with associated OCA & 2 EPAs	ITA with associated OCA & 2	ITA with associated OCA & 2
STAGE 2 GENERAL PSYCHIATRY EPAs x 4		1 of the 4 **e.g.** ECT	1 of the 4 **e.g.** Risk Assessment	1 of the 4 **e.g.** Cultural Awareness		1 of the 4 **e.g.** Mental Health Act						
STAGE 2 PSYCHOTHERAPY EPAs x 3 **STAGE 2 x 2** **STAGE 3 x 1**				1 of the 3 **e.g.** Therapeutic alliance[§]		1 of the 3 **e.g.** Supportive Psychotherapy[§]		1 of the 3 **e.g.** CBT[§]				
ADDITIONAL MANDATORY STAGE 2 EPAs		**e.g.** 1 ADD EPA (If not elective rotation)	**e.g.** 1 ADD EPA (If not elective rotation)		**e.g.** 2 POA EPAs (If not elective rotations)							
WRITTEN MCQ EXAM		*Eligible to apply > 6 months*				MCQ PAPER **PASS**[‖]	TL = 36	SC = 48				
WRITTEN ESSAY EXAM				*Eligible to apply > 18 months*						ESSAY PAPER **PASS**	TL = 60	SC = 72
OSCE EXAM						*Eligible to apply > 30 months*				OSCE **PASS**	TL = 60	SC = 72
SCHOLARLY PROJECT					**e.g.** Proposal / Method outline					SCHOLARLY **PASS**[‡]	TL = 60	SC = 72
PSYCHOTHERAPY WRITTEN CASE										WRITTEN CASE **PASS**[‡]	TL = 60	SC = 72

Trainee Reminders:
After 60 FTE months trainees must ensure their continued placement in an accredited training post with their service/BTC if Fellowship requirements are still to be completed.

- Summative assessments may be submitted/sat while on a BIT.
- Targeted Learning is not permitted on a BIT. The content and duration of the Targeted Learning depends on each trainee's circumstances. Case-by-case exceptions can be considered by the CFT.

Expected Fellowship attainment

TL = Targeted Learning (mandatory); **SC** = SHOW CAUSE to Committee for Training (mandatory); **BIT** = Break in Training

* = Months of accredited training time.

† = There is an exception for attaining two EPAs per rotation for the first rotation **only**.

§ = Psychotherapy EPAs: Must attain any 2 of the 3 Psychotherapy EPAs by the end of Stage 2. The third one can be attained by the end of Stage 3, still to a proficient standard.

‖ = The MCQ Exam is *not* a barrier to commence Stage 3 Generalist training. Effective mid-year 2016 intake, it is required for Certificate entry.

‡ = Allow time for marking.

required standards have been met. Supervisors have a duty to the trainee and the community to provide honest and accurate feedback.

Centrally administered summative assessments present higher stakes since results are recorded and failure may have academic consequences. Multiple unsuccessful attempts can impact adversely on training through time spent on study and preparation, and personal demoralisation. Before attempting these assessments a trainee should carefully consider what competencies need to be demonstrated, and that these are set at the standard of a junior consultant. Based on an understanding of where the various assessments sit within Miller's pyramid and the training trajectory, consideration should be given to how much training and experience is likely to be needed to attain and demonstrate the required competencies. For example, it would not be expected that a Stage 1 trainee would be able to demonstrate the application of knowledge required to pass the essay-style paper. Trainees are encouraged to get feedback from supervisors and Directors of Training, and to avail themselves of numerous resources available on the RANZCP website.

Examination reports by the Committee for Examinations (CFE) give feedback about common errors in approach. There is a bank of previous examination questions, and a practice MCQ paper. The education activities report provides pass rates and other information that may assist in decision making. This information may also help contain some of the anxiety about the process by providing facts rather than opinion.

The MCQ and essay-style examinations

In the previous RANZCP program the written examinations were attempted together in preparation for entry to advanced training. The cultural memory of more senior trainees and Fellows may urge trainees to continue to group the MCQ examination with the essay-style examination and to attempt both at the end of Stage 1. This is an error. It is unlikely that twelve months of training will provide sufficient time to have acquired the breadth of experience that leads to the junior consultant level knowledge and ability to demonstrate its application required by the Essay style paper.

The psychotherapy written case (PWC)

It may be tempting to try and achieve this milestone as quickly as possible, yet this summative assessment requires close work with a supervisor and considerable maturity in the write up of the case including an initial formulation and reformulation of the case. Considering the standard expected it may be unreasonable to hope to achieve the standard if the case is written up very early in training. The complexity of the psychotherapy case places it much closer to the apex of Miller's pyramid rather than the base. Feedback from the supervisor is a key element. During the process of psychotherapy and in preparation for the PWC, trainees must participate in three formative case discussions with their psychotherapy supervisor. These case discussions should be used as golden opportunities to reflect on the treatment process at the required level and to seek feedback. The Assessment Marking Sheet is available and should be used as a valuable reference point for the standard required.

The scholarly project

For quite a number of trainees this will be a project that spans much of their training. For some, competencies that allow the trainee to navigate this task as an early milestone may already be well developed in this domain. Discussion with supervisors and Fellows involved in local approval of planned projects will provide guidance around timing. Ethics approval may be needed and the time required must be considered.

The OSCE

The trainee progress trajectory indicates the College's view that trainees need considerable time in and breadth of training to gain the competencies to pass this examination. This examination requires the candidate to know, show and do.

From the supervisor perspective

Trainees may clearly be ready to undertake their assessments or clearly not. It is easy to give feedback to these two groups at the extreme. However, sometimes it can be difficult to appraise whether a trainee is ready to approach their assessments. Supervisors spend a good deal of time working with trainees who may be competent in the tasks required at work, but their ability to answer an essay question or perform in an OSCE station across the range of psychiatric disorders at the junior consultant level may be unclear. For the most accurate appraisal trainees may need to undertake mock examination/assessment tasks or draft their PWC or scholarly project. Working with other supervisors in this task provides calibration opportunities, as well as a more objective opinion at times. Directors of Training and Site Co-ordinators of Training are the immediate local Fellows engaged in training who can assist with standards if questions arise. Members of the Committees for Examinations and Training are also distributed across Australia and New Zealand.

Conclusions

The centrally administered summative assessments in the RANZCP Competency-Based Fellowship Program require trainees to demonstrate knowledge and skills at the junior consultant level, but the assessment tasks

involve different levels of competency in accordance with Miller's pyramid. It is essential that trainees are well informed of the nature of the assessment, both in terms of the knowledge and skills required, and the level of complexity of the task. They need to have a measure of their ability to demonstrate the required competencies at the junior consultant level which is best obtained by accurate feedback from supervisors and others involved in their training.

Disclosure

The authors report no conflict of interest. The authors alone are responsible for the content and writing of the paper.

Funding

The authors received no financial support for the research, authorship, and/or publication of this article.

References

1. Kealy-Bateman W, Lampe L, Cheung G, et al. In training assessment and the observed clinical activity. *Aust NZ J Psychiatry* 2015; 49(Suppl 1): 58.
2. Frank JR. *The CanMEDS 2005 Physician Competency Framework. Better standards. Better physicians. Better care.* Ottawa: The Royal College of Physicians and Surgeons of Canada, 2005.
3. Aimer A, MacDonald J, Date RO, et al. 2012 Fellowship program evaluation outcomes and report. *Australas Psychiatry* 2015; 23: 322–323.
4. Beeson MS, Warrington S, Bradford-Saffles A, et al. Entrustable professional activities: making sense of the emergency medicine milestones. *J Emergency Med* 2014; 47: 441–452.
5. Ten Cate O. Competency-based education, entrustable professional activities, and the power of language. *J Graduate Med Educ* 2013; 5(1): 6–7.
6. Miller GE. The assessment of clinical skills/competence/performance. *Acad Med* 1990; 65: 63–67.
7. Harden RM and Laidlaw JM. Be FAIR to students: four principles that lead to more effective learning. *Med Teach* 2013; 35: 27–31.