Education and Training in Psychiatry

A case study in the continuity of medical education

Edited by
Henry Walton

King Edward's Hospital Fund for London

Psychiatry is a subject relevant to all doctors. Psychiatrists treat only a small portion of the nation's psychiatric morbidity. A great bulk of psychiatric disorder is managed, adequately or otherwise, by doctors whose sole psychiatric training may have been as medical students. This book, therefore, gives particular attention to the place of psychiatry in the medical school curriculum. This has improved, during the course of a generation, out of all recognition: all medical students in the United Kingdom now have substantial teaching in psychiatry. However, this progress is now under new threat for reasons which are set out.

The book also deals with all the stages in the training of those entering psychiatry as a specialty. It is the first comprehensive review of its kind, and has not been carried out for any other medical specialty. It is, therefore, a case study with implications for all other medical disciplines.

All the educational and regulatory bodies concerned, from entry to training until appointment as consultant, are given attention and consideration is given to some of the indications of the future direction of psychiatry as a specialty.

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EDUCATION AND TRAINING IN PSYCHIATRY

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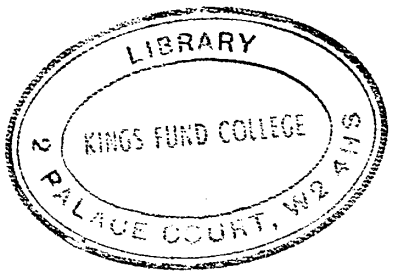
edited by
HENRY WALTON
Professor of Psychiatry, University of Edinburgh and
President, World Federation for Medical Education



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The Steering Committee

Appointed by the Royal College of Psychiatrists, the Association of University Teachers of Psychiatry and the Association of Psychiatrists in Training

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Dr Helena Waters (Secretary)
Professor S Brandon
Dr C P Brook
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Professor M G Gelder
Professor K Rawnsley
Dr R Scorer
Dr R Wilkins
Miss Jane Boyce (Administrative Secretary)

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Working parties were set up by the Steering Committee. The 14 working parties prepared the pre-circulated working documents for the Cambridge Conference. The membership of the working parties was as follows:

1 *Attributes of psychiatrists* Chairman: Professor S Brandon

Members: Dr E Gordon, Dr K Howell, Dr A King, Professor C P Seager

2 *Psychiatrists as role models* Chairman: Dr A Clare

Members: Dr S Greer, Dr R Higgs, Dr P Mullen, Mr K Sabbagh, Dr J Thompson

3 *The relationship between psychiatry and the professions closely related to it* Chairman: Professor M Shepherd

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Preface

The Royal College of Psychiatrists, the Association of University Teachers of Psychiatry and the Association of Psychiatrists in Training held a conference on 'Education and Training in Psychiatry' at King's College, Cambridge on 26–28 March 1982. The conference aimed to review the contribution which psychiatric teaching makes in the education and training of medical students and psychiatrists, and its effect on recruitment to psychiatry, a major theme of the conference.

The previous national conference on psychiatric training took place in 1969, when the educational objectives, the programme and methods for training psychiatrists were discussed; standards of proficiency were also considered and the organisational requirements for the future were reviewed (Russell and Walton, 1970). In 1971 a conference of the AUTP on undergraduate education was held in Manchester (Association of University Teachers of Psychiatry, 1971). Since those conferences took place the Royal College of Psychiatrists has come into being, the Joint Committee on Higher Psychiatric Training has been set up, the Merrison committee on the 'Regulation of the Medical Profession' has reported, and there has been a Royal Commission on the National Health Service, reporting in 1979. Of great relevance also is the financial stringency now affecting the universities: there have been adverse effects on staffing of university departments.

A Steering Committee was set up by the three parent bodies to organise the Cambridge conference. The Committee nominated working parties to prepare the pre-conference documents. These were published, made available to all conference participants, and copies have since been lodged in university departments of psychiatry and libraries of psychiatric hospitals. A number of working documents have also been published separately.

The Steering Committee remained in operation to organise a post-conference meeting at the King's Fund Centre in November 1983, in which representatives of regulatory and educational bodies, medical educators, and health service planners and administrators participated, to consider the implications of certain pressing issues emerging from the Cambridge conference.

The analysis in this report of the training of doctors in the specialty of psychiatry begins with a consideration of the place of psychiatry in

medical schools' curricula. The teaching of psychiatry to medical students has improved, during the course of a generation, out of all recognition: all medical students in the United Kingdom now have substantial teaching in psychiatry. However, this teaching is at hazard, for reasons which are set out in this report. The analysis also gives consideration to some of the indications of the possible future direction of psychiatry as a specialty. Because the report deals with education and training, covering the period from entry to medical school until the individual in training is ready for a consultant appointment, all the educational and regulatory bodies concerned are given attention.

While the report does not deal primarily with continuing medical education of experienced specialists, CME cannot be ignored when education and training for psychiatry is under consideration. Psychiatrists also have to undertake the lifelong learning now required of all doctors. Communication and cooperation of psychiatrists with doctors in other specialties is critically important. Psychiatrists treat only a small portion of the nation's psychiatric morbidity. A great bulk of psychiatric disorder is managed, adequately or otherwise, by doctors whose psychiatric training often is confined to their exposure to psychiatry as medical students. Liaison psychiatry is not advanced in the United Kingdom: hospital doctors in training for the other specialties are thus given little opportunity to learn more about psychiatry after graduation.

This report is the responsibility of the Steering Committee. It took account of developments in this specialist field following the Cambridge conference, and of the King's Fund meeting in November 1983 reported in the Appendix. The report aims to refer to those matters to which all concerned with the education and training of psychiatrists will want to give attention whenever the present and future status of the specialty is under consideration. Responsibility for the views expressed is that of the Steering Committee, and is not to be attributed to the parent bodies which sponsored the Cambridge conference, or to be assumed necessarily to reflect the views of these bodies.

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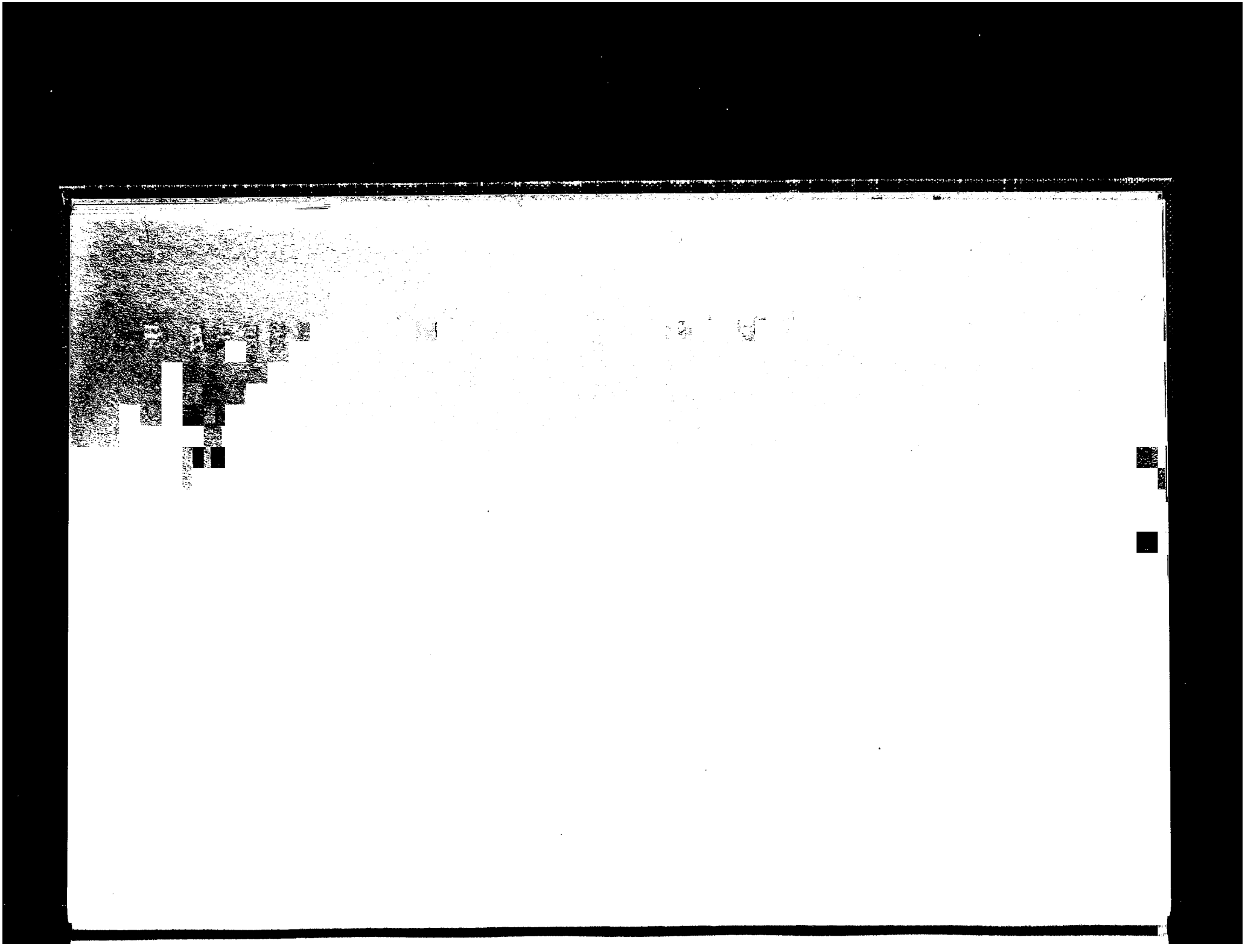

Introduction

Although this report deals with the training of a psychiatrist in Britain, from entry to medical school until the point of readiness to become a consultant, it is also presented as a paradigm of current views and practices pertaining to specialist training in all branches of medicine in the United Kingdom. The educational venture described —the training of a psychiatrist—is therefore of relevance to medical education as a whole. This comprehensive review, from entry to medical school up to the attainment of specialist status, has not previously been carried out for any other medical discipline.

Psychiatry is a specialty in the field of medicine. It is a branch of one of the foremost professions. Indeed, a recent publication (Goodland, 1984) has it that medicine 'is often seen as an archetypal profession'.

There is widespread uncertainty about the pathway leading to a person becoming a psychiatrist. The bewilderment was evident a few weeks ago when a young man came for personal advice about his own further training. He had just gained a PhD in philosophy, Kierkegaard his object of special study. Previously he had studied psychology, but had become disaffected by the emphasis he found on behaviourism. The advice he sought, given his conclusion that he wanted to prepare himself to work with people, was whether he would now be better advised to study clinical psychology or psychiatry? How exactly did one become a psychiatrist, he sought to find out? It reduced his uncertainty when he established that a psychiatrist is a medical doctor, while a clinical psychologist is not.

Education for any profession depends on the technical components assimilated during the professionalisation process, and considerations arise of who is controlling what knowledge for whose benefit. Professional training provides technical expertise enabling the professional to act appropriately in his specialist field, and it is negotiated by the institutions which control the intellectual, technical, social and political aspects of the particular profession. This report deals systematically with the medical school, the teaching hospital, the royal colleges, the joint committees of higher specialist training and, finally, the specialty itself, for manpower considerations—the type and number of psychiatrists—are an inescapable aspect of professional specialisation.

In turn, the chapters deal with access (application to medical school, selection procedures, dropout and wastage); curriculum;

teaching methods; educational objectives; assessment (and examinations); evaluation and accreditation; and with continuing education. Our aim is to deal with the full spectrum of the psychiatric professionalisation process up to readiness on the part of the trained psychiatrist to become an independent expert.

For a long time medicine has been the university subject most in demand. A total of 10,000 applicants annually seek to enter the medical schools. In Great Britain applicants are aged 18 years when they seek admission to medical school. They spend five years at medical school, and on average a further ten years after graduation in relevant postgraduate training before attaining their career grade. General practitioners usually take six years after the pre-registration year, and hospital specialists some 11 years (a longer period in Britain than elsewhere).

The goal during almost 50 years of medical education has been to alter the earlier medical school concept which was that of vocational training, to that of a university education in medicine, to be followed by postgraduate training appropriate to the particular specialty, and followed still later by ongoing continuing medical education. No doctor now trained has to rely any longer on his medical school education as the basis for his professional competence. His basic training, to repeat the important change in emphasis, is intended to prepare him for postgraduate training. The aim of the medical school is to produce a graduate who is able to assume limited clinical (or other) responsibility under supervision. Postgraduate medical training in the United Kingdom is exercised in a national health service in the context of a welfare state. Medicine, surgery and psychiatry, Reil said in the last century, constitute the three main branches of medicine. Surgeons and pharmacists in earlier times were regarded as practitioners of inferior crafts, subject to supervision by physicians.

The controlling body of medicine, the General Medical Council, is a state creation. The interdependence between the state and the medical profession is charged and ambivalent. Professional autonomy is regularly asserted as good and necessary (sometimes, in fact, to the general detriment) when greater cooperation and collaboration would be an obvious benefit to health care delivery. In the United Kingdom, by scrupulous prior consultation, the General Medical Council (and its Education Committee) has generally succeeded in obtaining compliance from the profession and the universities with its 'guidelines'. The General Medical Council has wisely allowed medical schools considerable divergence in their curricula, fostering innovation. In the United Kingdom each of the 36 medical schools conducts its own final examination. An important development through the Medical Act of 1982 was the statutory responsibility

of the General Medical Council for postgraduate medical education as well, thereby augmenting its longstanding responsibility for overseeing the medical school phase of medical education; the additional responsibility for the compulsory pre-registration year had been added in 1952.

As already indicated, when professional education in medicine is considered, the issue of control is prominent. Regulations govern the entry to medical education (on the international scene this is one of the most charged, pressing and potentially damaging issues, for there are still many countries allowing open entry to medical schools despite the gross over-production or, at any rate, mal-distribution of doctors); the content and form of curricula is controlled by the GMC; standards of achievement and definition of legitimate knowledge are prevailing academic concerns; licence to practise is rigorously guarded, as are the arrangements for providing services to the public. The knowledge explosion has contributed to the obligatory requirement that medical students have to be made self-directed learners; all doctors, in turn, have now to become lifelong learners, and this makes continuing medical education of experienced doctors a necessity. Ambitions on the part of professors to 'profess the subject' or to 'cover the ground' have become obsolete, and butter no parsnips any longer in curriculum committees.

Increasingly voices are raised, sometimes hesitantly and diffidently, to suggest that medical education and training is outdated, despite frequent revision or actual change, and needs reform because it is not in accord with the changed health needs of populations. Not only have traditional medical schools often lost touch with the type and range of doctors needed by the health services of the community in which the medical school is situated but, further, altered patterns of disease do not necessarily find recognition in medical school curricula. A recent publication, *Physicians for the Twenty-First Century: Report of the Panel on the General Professional Education of the Physician* compiled by the influential Association of American Medical Colleges (1984) states unequivocally: 'The Panel judges that the present system of general professional education for medicine will become increasingly inadequate unless it is revised'. Studies are appearing which document the dissatisfaction of patients with their doctors (Cartwright, 1964; Helfer, 1970; Ley, 1977, 1982).

Medical educators stand challenged that they have not adapted their medical schools and royal colleges to the changes that have occurred in society. Health promotion is all but ignored. Prevention and risk-reduction is largely overlooked. Modification of harmful lifestyles hardly features in curricula. Patients are not helped sufficiently by doctors to become aware of the range of options available

when they become sick, and the respective consequences of any medical intervention selected for them. Communities have too little say about the health services made available, and participate too little in decisions about them.

For the entrant to medical school, a medical education offers later entry to a wide range of varied specialist activity. The extensive range of alternatives is one of the assets of entering medicine that applicants to medical school regularly stipulate (Walton and others, 1976). To come into medicine is to put off a final career choice until later. A whole array of different careers is then open to the medical graduates. A proviso has to be expressed: specialist training tracks have become so lengthy, firmly prescribed and tightly regulated that it has become difficult for a doctor to shift from one career pathway to a different one, and we recommend that more occupational flexibility should become possible.

This book explains how a future psychiatrist embarks on a professional education, and the pathway along which educational training proceeds until the completion of specialist training is attained.

1 Psychiatry teaching in the medical school curriculum

Teaching of psychiatry relevant to all future doctors

Behavioural sciences and psychiatric teaching is called for throughout the undergraduate curriculum for all medical students, regardless of the branch of medicine they enter in the future. The broad goals in the teaching of psychiatry to undergraduate medical students, relevant to all future doctors, have been explored (Walton, 1968). When psychiatrists were questioned by means of a detailed questionnaire, they were found to advocate the teaching of five main sectors of psychiatry. (A less generally-agreed sixth sector will be mentioned, because those teachers who advocate it assign very particular importance to it.) In order of priority, these six aspects are: a) psychological-mindedness; b) an objective approach to behaviour; c) ability to make contact with psychiatric patients; d) symptoms, signs and syndromes (descriptive psychiatry); e) treatment methods; and f) self-understanding.

a. *Psychological-mindedness*: An important goal of teachers is to help medical students become more aware of patients' emotional responses, and to help students to understand the interpersonal relationship between clinician and patient in the medical interview. This aspect of the teaching therefore refers to the patient's and also to the student's subjective responses.

b. *An objective approach to behaviour*: This aspect of teaching sets out to make students aware of scientific knowledge about behaviour, so that they can distance themselves appropriately from the personal problems of patients (showing 'detached concern'), augmenting commonsense understanding with empirical knowledge. Behavioural science teaching is intended to promote such an objective approach.

c. *Ability to make contact with psychiatric patients*: Medical students frequently experience the same anxieties about mental patients that are customary in their society. Good psychiatric teaching should enable them to overcome prejudices and preconceptions, and relate clinically to a wide range of patients with psychiatric illness and disorder. To do so, students need skills in history-taking, in examining the mental state, and in psychiatric interviewing of a patient

repeatedly over a period of time. They also need an understanding of the inter-disciplinary team skills that will enable them to relate to members of the other professions engaged in providing psychiatric care.

d. *Signs, symptoms and syndromes*: Descriptive psychiatry, dealt with in the psychiatric textbooks, cannot be satisfactorily learned unless medical students have proper access to patients at the same time as the theoretical teaching is given. This clinical training, for learning clinical skills as well as knowledge, can be extended by videotaped presentation of psychiatric patients, ward rounds, case conferences, simulated patients and the many other clinical teaching procedures which are available.

e. *Treatment methods*: A great proportion of ill health is psychiatric. The psychiatric instruction given in medical school has to provide introductory knowledge about the main psychiatric treatment methods and skills, because much the greater part of the mental health needs of the community is met not by psychiatrists, but by general practitioners and specialists in other branches of medicine.

f. *Self-understanding*: Some departments of psychiatry aim to make the medical student more aware of his own psychological processes. Small group teaching has proved a useful method for enabling students to understand themselves better, when five to eight students meet together repeatedly with the same tutor (Walton, 1983). When the student hears his own voice on audiotape, or sees himself interviewing a patient on videotape, he can extend his own perception of himself as a clinician, the more so when he can review his competence in association with his fellow-students as well as with his teachers.

Student attitudes

It has been found that 'psychologically-minded' medical students showed a greater interest in and a more positive attitude towards psychiatry as compared with organically orientated students (Walton, 1969). Both Walton and Ghardirian (1972) found, independently, that medical students' preference for psychiatry as a future career was not affected by psychiatric instruction during their training. More recently Ghardirian (1981) has shown that certain learning experiences in psychiatry, particularly the clinical clerkship, can change attitudes towards psychiatry in a positive way. However, despite such increasing interest in psychiatry, and the fact that students came to attribute a greater importance to psychiatry as a

medical subject, very few (3.3 per cent) commit themselves to choosing psychiatry as their future career.

The many investigations by sociologists of medical schools, starting with Merton's investigation of Cornell in 1957, up to Judy Chuval's report on Israeli schools in 1980, have helped to demonstrate that the status of psychiatry, of teachers of psychiatry, and of psychiatric patients in medical schools is not at the level of, say, medicine or surgery. This has a seriously adverse effect on the teaching of psychiatry.

Medical students acquire their professional values and outlook, in large measure, by modelling themselves on leading and respected teachers in the medical school. Merton, for example, showed that the professor of medicine at Cornell was such an influential role model. Chuval (1980) has shown that medical students react to teachers in three different ways, by active identification, active rejection, or inactive orientation. The third of these responses, bland disregard, is now greatly less discernible in attitudes of contemporary medical students towards psychiatry than it was a generation earlier, when psychiatric instruction was less and poorer.

Medical school teachers in general tend to view psychiatry as a backward branch of medicine. They are unimpressed by the ideological differences among psychiatrists (one a biologically-oriented doctor favouring the medical model, the other a humanist concerned with psychodynamic processes and practising some or other form of psychotherapy). Medical school teachers are the more disconcerted when these contrasting ideologies tend to be adopted in an either/or manner; it can seem relatively arbitrary how any patient will be diagnosed and treated, appearing to depend too much on the psychiatrist to whom is he referred. Colleagues of the psychiatrist in other branches of medicine find the doctrinal differences among psychiatrists confusing.

The curriculum

Behavioural science teaching

The teaching of behavioural science should be regarded as an essential part of the undergraduate curriculum. There has been widespread failure of the teaching of these subjects with considerable criticism from students and from other preclinical and clinical teachers (Turnbull, 1978). The following general points are important:

1 Behavioural science teaching should begin early in the curriculum, preferably in the first or second year.

2 Clinically experienced medical and non-medical teachers should be actively involved in the planning of curricula and teaching.

3 Such teaching should be strictly relevant to medical practice and not by any means consist of a condensed general psychology and sociology course.

4 Behavioural science should be a compulsory and not an optional subject.

5 It should be examined along with other preclinical subjects and count towards professional examinations.

6 Separate behavioural science departments are not favoured and teaching should be inter-departmental with a university department of psychiatry taking an active part in the organising and coordinating of the course.

7 Teachers should be encouraged to introduce clinical cases into their teaching from the start.

8 Teaching should be centred around clearly stated educational objectives (an example for illustration of such objectives is given in Appendix I, page 28).

Behavioural science teaching has often not succeeded, in that students sometimes regard it as somewhat irrelevant or discordant with their main concerns, and the courses given have failed at times to be perceived as convincing or a substantial addition to the curriculum.

Interview techniques

Skilful and sensitive interviewing should be a part of every doctor's practice, and the teaching of interview techniques is an essential part of the undergraduate curriculum. Psychiatrists should not just be involved in the teaching of the psychiatric examination and interview but in interview skills relevant to all branches of medicine. Interview methods of teaching should occur early in the curriculum preferably as a preclinical subject.

Psychiatry teaching

Instruction in clinical psychiatry involves the teaching of the signs, symptoms, syndromes and treatment methods of psychiatry, and also the promotion of psychological-mindedness in students, the fostering of an objective approach to behaviour and, optimally, along with these skills some greater degree of self-understanding.

The following may be regarded as general objectives. The student should be able to:

1 conduct a diagnostic interview including a mental state examination;

2 relate a patient's symptoms to his past experience, personality and social circumstances;

3 give an account of his own emotional responses to patients of different kinds and the way in which these can influence his judgment and hence the patient's management;

4 give an account of patient's emotional responses to doctors and the way these can influence the presentation of illness;

5 outline the main principles of, and indications for, counselling and psychotherapeutic intervention.

An illustration of further objectives is provided in Appendix II, page 29.

A prolonged or repeated exposure to psychiatric teaching is preferable to an intensive package concentrated at only a brief point in the clinical curriculum.

Special opportunities for interested students

Students conveying special interest should be given opportunities for additional work as, for example, the projects undertaken at Southampton University, or the facility to follow-up a patient over a long term with close supervision (Garner, 1981); electives and additional clinical clerkships can serve a similar purpose.

Lectures and small group teaching

While lectures are an effective way of promoting factual knowledge and an efficient way of teaching large groups of students, they should not constitute the main form of psychiatric teaching. Small group teaching is expensive and time-consuming but must continue to be given a high priority by teachers, in order to enable students to develop the professional attitudes relevant to psychiatry. A combination of lectures and small group teaching is desirable, and is most effective (Walton, 1969).

The clinical clerkship

There is evidence that the type of the unit in which medical students do their clerkship in psychiatry influences their attitude to mentally-ill

patients (Eagel and others, 1979). The importance of psychiatry in general practice, general hospitals and in the community is not in doubt but there is still considerable value in at least a proportion of students having a clinical attachment in a mental hospital.

The following is recommended:

1 A full-time clerkship of eight to ten weeks' duration.

2 Wherever possible the clerkship should be on a single general psychiatry unit and no student should spend his whole clerkship entirely on a highly specialised unit.

3 The student should have both inpatient and outpatient contact.

4 He should have the opportunity to regularly see psychiatrists at work interviewing and treating patients.

5 The student should have the opportunity to interview patients himself and be involved in the decision-making about clinical management.

6 The student should be encouraged to see the patient in the context of his family setting and background. He should have the opportunity to visit a patient's home and assess such a setting.

A prominent aim of psychiatric teaching should be to find instructional approaches fostering positive attitudes to all patients, including psychiatric patients. The consensus is that such attitudes are provided through a clerkship. The indications are that it needs to be eight weeks at least in duration. Empirical studies indicate that attitudinal changes can be achieved and, moreover, are sustained.

Examinations

Psychiatry forms part of the professional examination in all UK medical schools (Crisp, 1973), though when it is part of a composite final examination psychiatry is sometimes construed as only a minor component and in some centres only a very few students are thus given a psychiatry clinical examination.

Continuous assessment during the clinical attachment is an important means of evaluation. NHS colleagues are asked to play a large role in psychiatry teaching and they should of course also be involved in the assessment procedures. Where, for practical or policy reasons, only a minority of students are given a clinical examination, there may be merit in supplementing such an examination with the writing-up of case histories. Most medical schools now make extensive use of MCQ examinations; in Scotland a joint MCQ has been in use

between the four universities which allows for interesting and informative comparisons to be made between differing patterns of psychiatric teaching.

The relation of psychiatry to other disciplines in the undergraduate curriculum

There is good reason for giving consideration to the relationship of psychiatry to other specialities in the undergraduate medical curricula:

1 There is need to integrate psychiatry with the other subjects in the curriculum on the grounds that any move towards isolation of psychiatry reduces the impact and scope of psychiatric teaching.

2 Psychiatry must be taught in conjunction with other subjects to inculcate a broad-based view of illness amongst medical students, who should appreciate from the beginning of their training that biological, psychological and social factors make varying contributions to all forms of illness and disability and their management. Thus, psychosocial and biological concepts should be equally familiar to them.

3 There are certain areas of the curriculum where natural alliances are relatively easy to fashion, chiefly because the specialties in question are acknowledged by the specialists practising in them to demand a knowledge of psychological concepts and diagnostic and treatment skills. Prominent among such subjects are general practice and paediatrics.

There is an increasing number of specialist areas within general medicine and surgery where similar opportunities for coordination or integration are to be found. They include: neurology and neurosurgery; cardiology and cardiac surgery; haemodialysis and renal transplantation; obstetrics and gynaecology; and oncology and hospice services.

Such special areas in medicine and surgery with a relatively high psychiatric content can only be brought into relationship with psychiatry through the development of liaison services. They are, of course, particularly valuable settings for medical student clerkships in psychiatry, with the medical students attached to such services receiving clinical teaching from the liaison psychiatrists who are attached to the units or services. Ideally this arrangement should operate also for the general medical wards, and other hospital areas (for example, in general surgery departments, orthopaedics, and the rehabilitation services that have been penetrated less effectively by psychiatrists)

where patients present with diagnostic and management problems because of psychosocial factors in physical illnesses or disabilities, or have psychiatric illnesses presenting in the first instance with physical symptoms. The policy for liaison meetings is especially important: psychiatry and medicine should meet on an equal footing, with equal time and opportunities for teaching; the obsolete arrangement for a psychiatrist to tag on to a medical ward round has been discredited sufficiently by unfortunate experiences in the past and should be avoided.

Teaching process

Explicit objectives, specified in accordance with educational principles, orientate the teaching to achieve a clear goal, that of helping all students demonstrate the extent to which they achieve the course objectives. The attainment of this goal depends on the learning experiences provided and on the effectiveness of the teachers.

Teaching methods

Teaching and its corollary—learning—can be provided in the immediate clinical setting, particularly by provision of clerkship attachments. Relatively active or relatively more passive learning can result. Passive and inefficient learning is a consequence of certain teaching methods, for example, lectures in formal settings, and watching experts 'perform' in an apprenticeship approach (although there remains definite justification for the latter—the learning of any skill calling for triple action: learning the relevant theory; watching an expert; and carrying out the activity oneself under proper supervision). Unfortunately, the more passive forms of learning often have the dubious advantage that they are sparing of teachers' time: one lecturer can cope with up to 200 students in a lecture, and apprentices 'watching' need not interfere with the clinician's daily work or schedule. The more efficient forms of active learning are time-consuming, and also require teaching skills of teachers that have to be acquired by teachers themselves. In psychiatry it is particularly in promoting psychological-mindedness and helpful self-awareness that formal teaching in time-consuming small group settings is essential.

Students themselves indicate that the features which facilitate clinical learning are: encouraging active student participation; positive attitudes towards teaching on the part of teachers; emphasis on applied problem-solving, rather than on learning of factual material; student-centred instructional strategies; a humanistic orientation of the teachers; and an emphasis on references and research results

(Stritter and others, 1975). Four of these features concern teaching methods and two concern personal qualities in teachers.

The most useful type of formal teaching is small group tutorials. Furthermore, they succeed in modifying negative professional attitudes most effectively. Each tutorial should have a clear focus with background references tabled beforehand, and medical students should be encouraged to use the tutorial to explore practical clinical problems, for example a tutorial group on the topic of self injury and suicide could draw up its own guides to assessing suicide risk and for implementing preventative policies. A tutorial on this topic could clearly lend itself to drawing out and modifying commonly held and unhelpful attitudes to mentally ill patients.

The danger in such tutorials is that they can lead to further information overload which already impairs medical teaching (Anderson and Graham, 1980). For this reason tutorial topics should not be comprehensive and should mainly promote problem-solving in psychiatry in an illustrative manner rather than attempting to cover the whole subject.

In the clerkship attachment, emphasis should be placed on students individually examining patients and writing up the case. These patients should be followed up by the student with the emphasis that progress notes are not to be simply passive observation of changes over time, but based on more active questioning by the student of the original working diagnosis, and also alterations by the student of treatment and management plans in the light of changes in the patient. Even in the clerkship setting, psychological-mindedness and self-awareness require to be promoted by formal teaching in small groups, for example, by asking a student to present one of his cases to a small group of students, the group then to use the student presenter and the tutor as resource persons with the student participants generating hypotheses. This is the group problem-solving approach (Engel, 1971). Televised interviewing, where each student interviews a patient and each interview is subsequently discussed by a small group of students, is a powerful teaching technique, again time-consuming and requiring considerable organisation to set up.

When both university and NHS resources are seriously under threat, the justification for the teaching personnel needed for this type of learning needs to be repeatedly stressed. Effective psychiatry is a time-consuming specialty; effective teaching in psychiatry is no less so.

Students in the early days of their psychiatric attachment tend to be perplexed, particularly if there has been no exposure, or unhelpful exposure, to behavioural sciences previously. Some also have considerable apprehensions about dealing with psychiatric patients. A

clear statement about objectives at the beginning of the course can help reduce the perplexity. If the teaching methods outlined above, however, are greatly at variance with the teaching students have received in other departments, this initially can cause further problems.

The teachers

Although teaching is an implicit responsibility of all doctors and is mentioned in the Hippocratic Oath, it has been repeatedly observed that teaching itself is given a low status in the promotion of academics and is suspected of not contributing much towards the achieving of merit awards among NHS clinicians.

Improvement in the teaching abilities of medical teachers, although little encouraged, is of great importance, particularly in psychiatry when the skills taught have a large subjective component. A very considerable amount of clinical teaching is done by NHS consultants, usually holding honorary university appointments. The teaching skills of non-university staff have thus to be recognised and encouraged. Academic staff need to take up places on courses on teaching methods which are run by most universities; the teaching skills required of university staff also need to be fostered responsibly in their NHS counterparts. Research to evaluate the effectiveness of teaching medical teachers has shown that not all can be helped to improve, and those that are improved need booster courses subsequently.

The implications are that courses on teaching methods which are run by the specialty itself are necessary, specifically orientated to teaching methods in psychiatry and aimed at not only university lecturers but senior registrars as well. These measures will only succeed if university representatives on consultant appointment committees for posts in teaching hospitals seriously take into account candidates' teaching performance. In view of the bulk of teaching done by NHS consultants, this approach would be a most effective method of improving the teaching of psychiatry.

University psychiatric units do have to provide teaching leadership and to undertake administration of courses. Since the bulk of teachers are not university staff themselves and since the success of teachers depends upon 'their willingness to review methods, resources and use of formal assessments' (Mayou, 1977), leadership skills of a high order are required, and a willingness on the part of university departments to involve NHS consultants in academic decision-making.

To encourage interest in teaching skills and to promote its status

as an academic subject within medical schools the following are suggested:

1 Instruction in teaching methods be a prerequisite of passing from a temporary to a tenured post for university lecturers.

2 Teaching skills should be periodically examined by fellow-teachers.

3 Student feedback must be obtained about all teaching provided.

4 Teaching skills should be routinely enquired about at consultant appointments and given the weight accorded to clinical competence and research experience.

EMPHASES

1.1 Psychiatry teaching to medical students includes behavioural sciences, theoretical instruction in psychiatry, and a clinical clerkship, and none of these basic components is dispensable.

1.2 The teaching of behavioural sciences is—in part at least—the administrative responsibility of the academic department of psychiatry, because later psychiatric instruction depends on prior learning of behavioural sciences (as long as the division between preclinical and clinical phases is a feature of curricula).

1.3 Clinicians must take part in planning and teaching the behavioural sciences teaching provided for future doctors. Teaching staff should thus include both psychiatrists and clinical psychologists, and the instruction must take place in the medical school and its clinical settings.

1.4 The complex interaction between NHS and university staff needs particular attention in planning and providing the psychiatric undergraduate teaching, especially at clinical level.

1.5 Instruction has to be provided in appropriate phases of the curriculum both by lecture and in small group teaching, and by provision of an obligatory clinical clerkship lasting at least eight weeks.

1.6 Conjoint and integrated teaching opportunities with other clinical specialties have to be fostered, and liaison psychiatry in the general teaching hospital has thus to be developed, if psychiatry is not to be regarded by the student as an isolated part of the curriculum.

1.7 It is a responsibility of academic departments to ensure that teachers of psychiatry have adequate teaching skills and interest in education.

1.8 It is crucial that in all medical schools there should be facilities for students particularly keen on psychiatry to pursue their interest, which should be fostered and encouraged.

APPENDIX I BEHAVIOURAL SCIENCES EDUCATIONAL OBJECTIVES

Psychology

By the end of the course each student should:

1 have acquired a basic overall knowledge of the findings, methodologies and theories of psychology which are relevant to the practice of medicine;

2 be aware of how a patient's emotions, attitudes, values and experiences influence his response to his illness and to its treatment;

3 have a knowledge of learning processes and their relevance to medicine;

4 possess normative data of the main aspects of psychological development of humans from birth to old age;

5 possess skills relevant to effective doctor-patient communication and particularly to interviewing;

6 have knowledge of techniques of assessment used to assess the reliability and validity of investigation procedures and therapeutic trials;

7 have attitudes to development that will enable him as a doctor to see each patient as a complete human being living in his own social environment.

Sociology

By the end of the course each student should be able to:

1 outline the various attempts to define and measure health and discuss their merits and limitations;

2 describe and discuss the importance of social institutions such as the family, the community, the economy and the law on health and medical practice;

3 describe and discuss the problems of equity and inequality in the provision and utilisation of health services, particularly when classified by age, gender, social class and region;

4 describe some of the more important changes in society and in the practice of medicine which have affected health and disease and the development of social policy;

5 describe the main reasons for the development of the welfare provisions, discuss the advantages and disadvantages of a nationalised health service, and appreciate the problems of planning for change within the National Health Service;

6 describe the social (and sociological) factors that influence the process of becoming ill and the doctor-patient relationship, and the effect that ill health and hospitalisation have on the lives of patients and their families;

7 discuss critically the role of preventive medicine and health education, and the role of self-help groups;

8 discuss critically the process of professionalisation;

9 describe some of the research methods used to evaluate health and medical practice.

Medical statistics (and scientific reasoning in medicine)

The aims of the course are:

1 to explore ways of making valid deductions from medical data;

2 to familiarise students with basic statistical terminology as found in the medical literature, for example *The Lancet* and the *British Medical Journal*;

3 to introduce the concepts necessary for designing as well as analysing comparison and experimental studies in medicine.

APPENDIX II OBJECTIVES FOR PSYCHIATRY TEACHING

General objectives

The student should be able to:

1 conduct a diagnostic interview including a mental state examination;

2 relate a patient's symptoms to his past experiences, personality and social circumstances;

3 give an account of his emotional responses to patients of different kinds and the way in which these can influence his judgment and hence the patient's management;

4 give an account of patients' emotional responses to doctors and the way these can influence the presentation of illness;

5 outline the main principles of, and indications for, counselling and psychotherapeutic intervention.

Organic psychiatry

The student should be able to:

6 distinguish between organic and non-organic (functional) psychiatric disturbance;

7 describe and recognise common organic psychoses (acute and chronic) for example, delirium tremens, senile dementia;

8 list the common causes of confusional states and dementia in different age groups;

9 describe the management of acute confusional states;

10 describe the management of dementia in and out of hospital.

Functional syndromes

The student should be able to:

11 distinguish between a depressed mood and depressive illness and describe in detail the management of the latter;

12 diagnose schizophrenic and related psychoses, outline the management of acute attacks and describe the management of the chronic illnesses in the community;

13 describe and recognise common symptoms of neuroses;

14 define and recognise the signs and symptoms of psychiatric illness important in differentiating the major syndromes, for example, flight of ideas, passivity experiences;

15 describe and recognise the features of normal and abnormal grief and outline their management;

16 recognise the diverse clinical presentation of alcohol dependence and describe the syndrome;

17 describe the management of alcohol and drug dependence;

18 describe and recognise the common forms of psycho-sexual disorder and outline the principles of their management;

19 discuss the common causes of acute emotional disturbance in different age and social groups and outline the principles of crisis management especially in relation to parasuicide;

20 assess the risk of suicide in depressed patients;

21 describe and recognise the common psychological problems of childhood and adolescence;

22 describe and recognise the common psychological problems of old age and outline the social services available for their management.

Treatment methods and agencies

The student should be able to:

23 outline the psychiatric effects of drugs commonly used in medical practice, including corticosteroids, anti-hypertensive agents, opiates, oral contraceptives, barbiturates, sulphonamides and anticonvulsants;

24 list the main indications, contraindications and unwanted effects of (a) phenothiazines (b) tricyclic antidepressants (c) MAOIs (d) benzodiazipines (e) lithium salts;

25 outline the principles of behaviour modification and their main clinical applications;

26 discuss some clinically important concepts in psychodynamic approaches, for example, unconscious conflict and defence mechanisms such as projection and denial;

27 list and describe the main agencies for the care and rehabilitation of the psychiatrically ill and mentally handicapped in the community.

Other objectives

The student should be able to:

28 describe the main psychiatric disorders found in children, and the methods for investigating and treating these conditions;

29 describe the social and psychological problems of the mentally handicapped;

30 describe and recognise the common psychological reactions to physical illness;

31 outline the psychological mechanisms which can produce somatic symptoms and influence the course of physical illness;

32 describe the common associations between crime and mental illness;

33 outline the conditions under which it is legitimate to detain patients in hospital and treat them against their wishes.

2 Teaching methods in psychiatry

The primary objective of psychiatric teaching to medical students is neither the recruitment of psychiatrists nor to provide instruction about specialist psychiatry. Nineteen out of every twenty medical students will not become psychiatrists and the responsibility to them is therefore to enable them to learn the psychological aspects of medical practice and to contribute to their general medical education. Professional training in psychiatry, on the other hand, is of course the concern of psychiatrists, but equally important in the postgraduate field is the contribution which psychiatrists can make to the general professional training of other doctors. 'The psychiatry needed by the nation cannot possibly by provided by psychiatrists, it is a task for all doctors' (Walton, 1984).

Particular emphasis needs to be given to the critically important concept that the whole of medical education and training is a continuum. Learning provided at medical school has implications for the pre-registration period, general professional training, higher training, and lifelong continuing education.

The contemporary doctor in Europe (and North America) is prepared by undergraduate training, which equips him to enter postgraduate graining, and after specialisation or as a general practitioner he should then uninterruptedly engage in continuing medical education (CME).

Teaching methods will be different for each phase in this professional continuity. This chapter deals mainly with medical school teaching methods (focused on psychiatry). Postgraduate training consists of learning by doing, under supervision. There is no curriculum for CME: the experienced doctor should learn mainly 'on the job', tuitional and educational materials conveyed to him—hence the importance of the new developments in distance learning.

The teachers

The image of psychiatry and the influence of psychiatrists as role models exerts an influence upon the receptiveness of students and upon their selection of psychiatry as a career. Reports suggest that students, particularly postgraduates, are turned against psychiatry by their experience of the management of self-poisoning and other crisis contacts between psychiatry and other specialties (Creed and Pfeffer,

1981). Improvements in the liaison psychiatry services in general hospital can reduce these negative perceptions.

The psychiatrist needs to be seen as an effective clinician, therapist and administrator, with a contribution to make to other medical disciplines. A substantial proportion of young doctors, 25 per cent of graduates, view psychiatry as concerned with chronic cases (Hutt and others, 1979), clearly having been deprived of learning opportunities for grasping acute psychiatry, and the interface between psychiatry and other branches of medicine.

The subject

To be effective the teaching must emphasise the breadth and humanitarian aspects of psychiatry and the close concern it has with the problems of living, perhaps more so than in any other branch of medicine. Teachers should be chosen on the basis of their ability to teach with enthusiasm and to relate to students and to patients with empathy and encouragement. Although teachers themselves need training in teaching, training courses for teachers are not effective in all instances, and it therefore needs to be accepted that not all psychiatrists should teach.

Enthusiasm in teaching and models of good care depend upon proper working conditions in medical schools, departments of psychiatry and teaching hospitals, all equipped with adequate resources. Overburdened teachers and inadequate services cannot provide a balanced training.

The clinical clerkship

The importance of the teacher and of his working conditions are central to the clinical attachment model which remains the core of good undergraduate (and postgraduate) teaching. Active teaching methods which involve the learner are superior to passive ones, and the provision for relating to both teachers and patients facilitates clinical maturation (Walton, 1984).

The clerkship attachment must provide opportunities for the discussion of the possible meaning of the patient's experience and its relation to his life circumstances. The significance of objective and scientific data concerned with social, epidemiological and psychosocial aspects of mental functioning in health and in illness should also be learned, and these elements should be introduced into the curriculum as early as possible. This teaching may serve to reduce an anti-psychiatry bias in a student, or overemphasis on high technology medicine on the part of some medical teachers. On the other hand psychiatry, when well taught, may attract undergraduates disil-

lusioned by an undue preoccupation with the technical aspects of investigating and treating disease while the patient who is ill is relatively minimised.

Psychiatric outpatient clinics in which the student clerks and presents the patient to the consultant are effective teaching experiences, and ensure that ambulant patients as well as inpatients feature in the clinical instruction.

Interview training

During psychiatry teaching, and ideally also earlier in his pre-clinical career, the student can benefit from the teaching of interview techniques. The effectiveness of such teaching has been demonstrated (Sanson-Fisher and others, 1979).

The value of allowing the student to watch or listen subsequently to his own interviews has been emphasised (Sanson-Fisher and others, 1981). Videotape provides an ideal medium, but listening to simple audio recordings also inculcates skills in perceiving and paying appropriate attention to a multitude of cues which are evident in even a brief interview.

Feedback from a tutor can help the student to understand the interpersonal process and is as effective when given in a group as when given individually, and much more effective than when the student is working on his own. Training in eliciting the history from a patient increases students' ability in essential skills, such as the elementary steps of introducing themselves to the patient and in orienting the patient to the task in hand.

Medical students as well as postgraduates can gain from training in interview skills through the use of video recordings, not only of history-taking but also extended to mental state examinations. Attention can be focused on the technique of eliciting the phenomena as well as on analysis of the significance of the signs and symptoms thus detected.

Video recordings of any interview occurring during routine clinical work can form a good basis for teaching. Everyday concerns of psychiatric management, such as the prescription of ECT, the decision to permit weekend leave or the review of a weekend at home, all provide a valuable focus for learning and discussion.

Family therapy and individual psychotherapy training can also be augmented greatly by the use of videotape. An experienced therapist can benefit considerably from a regular review of a fragment of one of his interviews, and the benefit of such instruction to medical students is correspondingly large. Skills in observing and responding to verbal and non-verbal cues can be sharpened through systematic addition of

the new dimension to supervision which is added by the use of videotaped sessions.

Role playing: The student adopting the role of a patient or of a clinician in the presence of his instructor or peers can be most useful in the undergraduate phase (as it can in postgraduate training) in learning basic technical skills and in exploring some of the possible factors contributing to a particular difficulty which a student may experience in interviewing or therapy.

Lectures and seminars

Well-presented lectures remain valued by students and are an economical means of presenting information, but are much less likely to stimulate the student's interest than small seminar teaching in which the students' own contributions are sought and incorporated as learning material. Particular emphasis is now given to reducing the number of lectures, a main recommendation of an important report issued by the Association of American Medical Colleges (1984). Regular seminars with the same tutor can serve to stimulate and maintain the students' interest in the subject matter, which may range from basic concepts to complex critical reviews of research material. Seminars should encourage the student to read constructively on his own, and train him to evaluate written material or verbal presentations critically.

Self-instruction and distance learning

Very considerable developments are occurring in methods of instruction which medical students or experienced clinicians can utilise on their own, although these have been mainly developed in postgraduate education. Monthly audiotape programmes have been issued; for example, the American College of Psychiatrists has a continuing medical education programme named 'Update' (1981), which counts as part-recognition for personal accreditation of psychiatrists, when an audiotape of a lecture or panel discussion is backed by printed material and recommended reading. Each programme begins and ends with self-test programmes. An elegant 'Clinical Continuum in Psychiatry' has been compiled which contains 12 audiotapes with corresponding transcripts of the dozen panel discussions, on such subjects as personality disorders, liaison psychiatry, the psychotherapeutic process, the laboratory in clinical practice, and the psychiatric evaluation.

Most use has so far been made of methods with the advantage of low technology requirements in production and readily accessible

means of playback, such as cassettes for use at home or audiotapes played in cars, as well as in groups or other formal teaching settings. Tape-slide presentations are now well established, developed by bodies such as the Graves Tape Library, but relatively few programmes have been prepared in Britain for psychiatric teaching for medical students.

Videotape presentations in VHS format which can be played on domestic video recorders are an important current extension of learning methods. Many departments and centres now provide much more sophisticated systems for self-instruction. In the Manchester Department of Psychiatry a self-teaching studio contains a video recorder and monitor with instructions on the use of the equipment and a catalogue of available tapes. (In eight years no person has wilfully damaged the equipment or stolen a cassette.) There are four basic types of tape available at Manchester: illustrations of clinical syndromes; instructional tapes about technical approaches such as relaxation therapy or hypnosis; extra-curricular tapes showing syndromes or techniques which do not form part of the basic course; and a variety of self-test tapes. The Association of University Teachers of Psychiatry has made a series of videotapes for psychiatric instruction, each tape the production of a different university department of psychiatry.

Videotape can therefore now be used in the same manner as audiotapes have long been, as the main component of a sophisticated and varied teaching package.

In continuing medical education, other technical approaches will be especially encumbent on educators in the future, including audit, peer review and distance learning.

Clinical teaching

Ward rounds, case conferences and participation in consultations, including domiciliary visits, remain important elements of clinical teaching for medical students.

Self-study methods, such as those developed for the continuing education of consultants, have great promise. Many are especially appropriate for distance learning and are a most important means for the maintenance of standards and are the basis of quality control in later professional practice. These learning approaches in undergraduate education have hardly been at all exploited in psychiatry. They all become increasingly relevant as more instruction comes to be given away from the teaching centre, as medical schools increasingly use as a teaching resource the neighbourhood clinics and health centres of the community in which they are sited.

All medical students should of course have the opportunity of working with experienced psychiatrists. This is to some degree achieved by the clerkship attachment which naturally needs to be augmented, as when teaching sessions are provided for a larger group of students to view an outpatient consultation by using closed circuit television. The method calls for an experienced consultant to meet the student group to discuss the referral letter and the way in which this predetermines the opening phase of the interview. On completion of the interview, witnessed on closed circuit by the students, both the clinical features and the conduct of the interview can be discussed. A variety of opportunities result to inform and educate the student, as well as to provide a model of good practice. Recent research into the clinical approach of experienced doctors shows that they rapidly construct four or so hypotheses about the patient's possible disorder, and then proceed to confirm and disconfirm them in the clinical interview.

Teachers in psychiatry have yet to give appropriate attention to their special responsibility in educating future doctors in 'soft skill competencies' (Spencer, 1983) or at least being aware when students conspicuously lack them. These are the necessary attributes—yet to be appropriately defined by the relevant technical methods including critical incidents analysis (Flanagan, 1954)—which all doctors require over and above their specific technological competence. It seems likely, for doctors (as well as for members of other professions), that the soft skills discriminating excellent from average doctors will be related to the triple constellation already identified for other professions: non-verbal empathy; speed in appraising the wider social context; and positive expectations, that is, a belief in the ability and worth of others.

EMPHASES

2.1 Psychiatric skills should be seen as an integral part of the skills necessary for all doctors. Psychiatrists should make a major contribution to training in interviewing through liaison psychiatry in general hospitals, and other teaching approaches which emphasise the importance of a psychological orientation to the management of patients in general (and not only those with formal psychiatric illness). Such developments will raise the standing of psychiatry in medicine generally and attract able recruits to the specialty.

2.2 Medical students should be exposed to good practice by learning from experienced psychiatrists as well as through clinical attachments allowing them to participate actively in patient care. Watching

an outpatient consultation on closed circuit television and attending liaison psychiatry rounds or meetings, when the senior medical student is included as a member of the psychiatric clinical team, are important ways of augmenting clerkship attachments.

2.3 The psychiatric instruction of the medical student should not end with graduation, as is the case far too often at present (in almost all specialties except general practice). All doctors should have access to good psychiatric practice during their pre-registration and general professional training years through the availability of psychiatric pre-registration house jobs, good psychiatric liaison services to medical and surgical firms, and the provision of a special teaching input by psychiatrists for all doctors in the training grades. It is no longer acceptable that the only psychiatry most doctors learn is as medical students.

2.4 The need for some psychiatric component in the general professional or vocational training of all medical specialists is also pressing, but more difficult to achieve.

2.5 Teachers require to have both time and enthusiasm to participate in teaching and this must be recognised in providing resources made available for psychiatric teaching. Although much can be done with simple and inexpensive teaching methods, more sophisticated approaches, such as those using closed circuit television and videotape, are also needed, and their cost-effectiveness is well established.

3 The attributes of psychiatrists

Introduction

Serious reservations must be expressed about the completeness and comprehensiveness of the information available regarding the reported attributes of psychiatrists; the features of a 'good' psychiatrist are difficult to delineate because of the lack of good information about attributes of competent psychiatrists. Critical incidents analyses of psychiatrists are greatly needed (Flanagan, 1954) to obtain objective criteria of the attributes differentiating good psychiatrists from average ones. This approach calls for investigation on the basis of self-reports by specialists of the activities they engage in when providing clinical care, planning services, undertaking administration, and so on.

No critical incidents study of psychiatrists has yet been done. Studies of the attributes of psychiatrists have been mainly undertaken in the United States and have often focused upon psycho-analytic or office practice rather than on general psychiatry as practised in the United Kingdom. Sir Denis Hill gave a lecture on 'The Qualities of a Good Psychiatrist' in 1978; Henry Walton and his associates (1963) studied the career preferences of medical students and identified personality correlates of medical students with a career interest in psychiatry; Brook and others have surveyed the students in a number of medical schools; and other workers have examined career preferences and the factors influencing choice of career in medicine in general and psychiatry in particular.

Few studies have addressed themselves to the wisdom of that career choice for the individual, his patients or society. Wanting to do something is not necessarily justification for the goal. Goethe warned: 'Beware of your aspirations, for they will come to pass.' It is apparent from certain studies that the choice of psychiatry by some practitioners was influenced by the favourable career prospects in a shortage specialty, the opportunity for a more flexible training programme than in the other specialties, and the comparative protection from some of the stresses of acute medicine. The second reason is cogent: medical training leaves open the individual's later work role, because medicine offers a great range of possible future careers.

The task of the psychiatrists

In the various descriptions of the role of the psychiatrist there is often insufficient differentiation between his clinical and administrative functions. His primary task may thus become identified in totally different ways. One view taken is that his main responsibility is providing continuing care or treatment for functional or organic psychiatric disorders in patients referred to him by other doctors. Another view taken about priority is that of giving support to the non-psychiatric primary care team in the community; acting as adviser or consultant to other medical specialists may be the emphasis accorded; or the psychiatrist may be viewed primarily as a leader of a therapeutic team working in hospital and/or the community. There are yet other major responsibilities that can be identified for the psychiatrists: one such is as agency consultant to residential homes, social service agencies or schools, or as administrator of a hospital or community service, or in any combination of these and other diverse roles. How the psychiatrist gets his patients, or whether other health personnel should get them rather than the psychiatrist may also be at issue. Referrals to the psychiatrist may be seen as appropriately coming exclusively from medical sources; or through social workers, psychologists or voluntary agents as well; or directly from the patient or his family or social network.

To complicate the situation further, a definition of his role may be assumed by the psychiatrist which may differ totally from that of his employing authority and his potential patients or clients.

Another contentious viewpoint, considered in detail in Chapter 17, seems to be an assumption that psychiatry may well be a field of work which can be undertaken in some or all its aspects by general practitioners, social workers, psychologists, counsellors, psychotherapists, nurses, the rehabilitation professions and even by community volunteers. Despite evident and desirable overlap of function between these various professional groups, and indeed the evident success of some self-help ventures such as Alcoholics Anonymous or encounter groups (Lieberman and others, 1973), this shallow assumption is to be firmly rejected. There are now investigative methods by which the unique tasks and scope of the psychiatrist and his skills can be specified (Flanagan, 1954), at the same time as the boundaries of psychiatric knowledge are carefully defined (McClelland, 1976; Pottinger, 1977).

Despite varying professional ideologies, and hence a wide difference of opinion among psychiatrists regarding the very basis and practice of psychiatry, a common core of responsibility and expertise can be identified. The psychiatrist, in the first place, is primarily a

physician and an active clinician. The late Erwin Stengel has explained that the qualities which distinguish the psychiatrist from any other physician are those which come from his psychological knowledge and psychological skills, a statement Hill amplified by referring in addition to 'his particular attitudes to his field of work'.

An early survey of expert opinion on the criteria for defining a good psychiatrist was conducted with those responsible for directing the large training programmes for psychiatrists in America by Karl Menninger. Subsequent studies have modified the list of qualities in some respects. The specification advanced by Holt and Luborsky (1958) is shown in Table 1, (below and page 42).

The extent to which the psychiatric perspectives in vogue can

Table 1 Qualities of psychiatrists

Qualities to be sought in applicants for psychiatric training	*Qualities characterising the trained (effective) psychiatrist*
I *Abilities and capacities*	
	A. Intellectual
Superior intelligence	1 Intelligence
	2 Common sense
	3 Observational ability
	4 Imagination
	B. Interpersonal: receptive
1 Intuitiveness	1 Intuition
2 Capacity for understanding	2 Sensitivity to subtle dynamics of human behaviour
3 Empathy	3 Empathy
4 Psychological-mindedness	
	C. Interpersonal: interactive and relational
1 Verbal facility	1 Verbal facility
2 Capacity to attract friendship	2 Likeability: ability to win affection
3 Ability to interrelate with many types of people	3 Ability to interrelate with many types of people
	4 Ability to win respect and trust
5 Ability to work harmoniously with institutional colleagues	5 Ability to work as a member of a team; absence of annoying traits
6 Leadership ability	6 Ability to raise morale, maintain serene atmosphere
II *Attitudes, interests and values*	
	A. General characteristics of attitudes and values
Breadth of (non-medical) interests	Breadth of interests
	B. Interest in psychiatry
	1 Interest in subject matter
	2 Preference for dynamic concepts

Table 1 Qualities of psychiatrists–*continued*

Qualities to be sought in applicants for psychiatric training	*Qualities characterising the trained (effective) psychiatrist*
C. Attitudes towards patients and people generally	
1 Interest in people	1 Interest in people
2 Concern with human problems in their universal aspects	2 Concern with human problems in their universal aspects
	3 Respect for the dignity and integrity of the individual
4 Tolerance	4 Tolerance
	5 Sense of social responsibility
	6 Therapeutic optimism
III *Other traits of personality*	
A. Adjustment	
1 Maturity	1 Maturity
2 Emotional stability	2 Emotional stability
3 Relative freedom from symptoms	3 Relative freedom from symptoms
B. General evaluative traits	
1 Integrity of character	1 Integrity: truthfulness
2 Sincerity	2 Sincerity
3 Stature and breadth of personality	3 Stature and breadth of personality
4 Acceptance of responsibility	4 Dependability
5 General appearance and manner	5 General appearance and manner
C. Emotional and interpersonal traits	
1 Emotional warmth	1 Warmth
	2 Sympathy, kindness, considerateness
	3 Cooperativeness
D. Interpersonal Traits	
1 Independence without hostility to authority	
	1 Inner confidence
2 Extraversion	

Source: Holt R R and Luborsky L (1958). Personality patterns of psychiatrists. New York, Basic Books.

depend on a particular era and culture is evident from this pioneering specification. The ethos of the time led to the inclusion of 'Communist beliefs' as a negative quality and 'Preference for dynamic concepts' (IIB2) as a required positive value; other preferences now energetically supported in this time and place may later come to be as dubious. There are some psychiatrists currently responsible for training who would regard overt homosexuality as a necessarily undesirable attribute (a view which some others may not share); and the fact that egocentric traits are sufficiently evident in some of the most

prominent of present-day psychiatrists argues against their being viewed as necessarily a disqualification. Among interpersonal traits the positive weight given by Holt and Luborsky to extraversion would also now be questioned (Walton, 1969).

Denis Hill emphasised the need for a critical attitude towards the nature of evidence, the capacity to evaluate it, 'the understanding of what is knowledge and what inspired guesswork or authoritative statement' and the ability to distinguish between them. The clinician, Hill claimed, must tolerate the discrepancies in the quality of psychiatric knowledge 'without recourse to any of the common methods of escape, such as clinical non-commitment, denial or disdain of psychiatry, or by contrast a contempt for the relevance of knowledge or a shallow pretence to it' (Hill, 1978).

Although research ability is not an essential attribute, the good psychiatric clinician must nevertheless be alert to advances in clinical research and be able to appreciate and evaluate them. It needs also to be recognised, however, that the clinical scientist who seeks only after objective facts and never gives weight to subjective experience is a potential menace with individual patients, partly because he is not prepared to take action on inadequate data, an inescapable necessity in clinical decision-making and management. The pioneering specification of Holt and Luborsky is also gravely at fault in that it pays insufficient attention to the importance of the ability to relate to other professionals, to understand the nature and extent of their knowledge and skills, and to respect their professional independence.

Selective recruitment

The high psychiatric morbidity and mortality reported among psychiatrists may be related as much to selective self-recruitment to the specialty as to the stresses of psychiatric practice; thus both personality attributes and the particular personal pressures involved in psychiatry need to be recognised.

One-third of doctors make their career decision about eventually becoming psychiatrists before entering or while still in medical school. There is some evidence from the United States that more than half of those with an early intention to practise psychiatry change their minds before graduation; Brook and others found in the UK that six per cent of students were strongly interested in psychiatry on entry to their clinical course, but this fell to three per cent for final year students. There is some evidence that success in psychiatric undergraduate examinations is associated with early entry into psychiatric training.

Among a group of recently appointed consultant psychiatrists,

over one-quarter were women and one-third were overseas graduates. Although one-third of the group overall had made the decision to enter psychiatry before entering or while in medical school, this was true of nearly half the home graduates, but true of only one-fifth of those who had graduated overseas. Three-quarters of home graduates but only half of the overseas graduates indicated that psychiatry was their first choice of specialty. Of the women, one-third had trained part-time, and their career choice was heavily influenced by considerations of geography and family circumstance.

There does not appear to be evidence to support the assumption that an early choice of psychiatry as a career is associated with neuroticism or abnormality of personality; Walton (1969) found that senior medical students drawn to a psychiatric career were similar in their proneness to anxiety to students who were negative towards psychiatry as a future career. Are then the popular stereotypes of the eccentric or mentally abnormal psychiatrist a myth? Is the morbidity concentrated in the later entrants to training, or is the nature of psychiatric practice responsible for the emotional vulnerability of psychiatrists? There is no good data as yet on these questions but it is certainly possible to identify some of the stress factors in psychiatric practice.

Stress

The stability and equanimity of psychiatrists may be considered under a number of headings. In many branches of medicine a major source of gratification or satisfaction is the evident admiration and gratitude which patients and their families feel for their physician. In the field of psychiatry patients may be unwilling to engage in treatment or resentful that they have to seek and accept help. Many patients with psychiatric disability are relieved and consoled if their disorder can be construed physically rather than psychologically. Successful psychiatric therapy, particularly in the young, often involves a rebellious or critical disengagement from the clinician as the patient improves. Such resentment, hostility and rejection by many patients may be difficult for the psychiatrist to tolerate unless he has other sources of satisfaction or reassurance.

Many patients suffer from chronic disability which may be difficult or impossible to modify. Thus chronic schizophrenia, dementia and severe personality disorder are all conditions which require the clinical commitment of the psychiatrist, often protractedly, but constitute taxing care which may offer little immediate satisfaction. Acute emotional crises, neurotic states or psychosis may all make grossly disturbing personal demands upon the psychiatrist, because of the very fact that the relationship between doctor and patient is his

major therapeutic resource. Empathy with distress, while crucial for the patient, is emotionally draining to the psychiatrist and many situations or disorders carry intimations of his own vulnerability, and the limitations inherent in the human condition, to which imperatively the psychiatrist must always remain alert in himself.

In contrast, the intense nature of the treatment relationship, the plight of acutely disturbed patients, the intimate nature of the therapeutic relationship and the operation of transference and its technical aspects (the counter-transference) facilitate the development of intense emotional relationships. Jaspers (1963) emphasised that psychiatrists are privileged to know people at extremities of existence. There are often strong pressures from the patient to proceed beyond the boundaries of the professional relationship. In certain neurotic illnesses and by certain personality-disordered individuals manipulative behaviour is common; at times it takes the form of seductive approaches towards the psychiatrist. The insights into the behaviour of others and the powerful roles which must at times be assumed by psychiatrists are not necessarily associated with personal insight; exceptionally there is a risk of emotional involvement leading to a physical intimacy or to dependence upon the patient; on the other hand, self-aggrandisement or professionally inappropriate and unnecessary self-gratification is potentially a miscarriage in the treatment relationship.

Psychiatric practice is both labour-intensive and personally involving; at any level of seniority a psychiatrist is and should be engaged in face-to-face interaction with patients. An orthopaedic surgeon may be physically exhausted but exhilarated after an afternoon clinic in which he 'sees' 40 patients, whereas his psychiatric colleague may have had only two or three appointments in the same space of time yet be emotionally drained. A surgeon may delegate much of the routine of diagnosis and treatment to his junior staff so that a ward round or operating list consists of a focusing of his particular skills on a succession of patients. The senior psychiatrist by contrast has to recapitulate the history-taking and examination of each patient with the staff involved and then personally engage with the patient, or fulfil a supervisory role involving a direct relationship with the clinician to whom he has delegated responsibility.

Managerial and administrative responsibilities

Apart from the stresses of direct patient contact, the psychiatrist in the NHS has to maintain a multiplicity of relationships and administrative tasks for which he is often untrained and frequently disinclined. The notion of ultimate clinical responsibility and the structure of the health service impose upon the psychiatrist a leadership role

which, if exercised, may result in allegations of assumed omnipotence; and if neglected, of the abrogation of responsibilities (an accusation which has featured in a succession of hospital enquiries). Relationships with other health professionals are in themselves demanding upon the individual psychiatrist under such circumstances and are often complicated by interprofessional rivalries and identity struggles. These can be constructive if ably responded to, but that again entails self-vigilance and can be emotionally wearying.

Relationships with psychiatric colleagues are often surprisingly remote, with little contact other than through formal administrative or educational activities. (Where this obtains, it is in itself a powerful argument for peer review arrangements.) With non-psychiatric medical colleagues there is often a notable ambivalence. A psychiatrist may attend rounds or a case conference on a medical or surgical unit, but informal visits to a psychiatric unit by physicians or surgeons are a rarity. Explanations for tension and unease are not difficult to find in terms of both practice style and psychopathology: that psychiatrists defend themselves by *ad hominem* reproaches directed at non-psychiatrist physicians is of course to be deplored, but even unexpressed attitudes can foster tension with colleagues.

Psychiatrists often attempt to overcome this isolation or strive to achieve credibility by adopting elements of acute hospital care styles which are not always advantageous to their patients or their practice. Since the credibility of psychiatrists and psychiatry is an important factor in both the provision of resources and the referral of patients, these relationships merit more study than they have yet received.

Antipsychiatry

The long-term effects of the antipsychiatry movement which began 20 years ago are difficult to assess. Many psychiatrists have felt under attack from numerous public, lay and professional sources regarding the very foundations of their practice. The ability to withstand criticism, censure or even abuse whilst retaining the ability to respond to changed health needs and shifts in delivery of care are important attributes.

Catch 22 situations are not unknown. For instance, as the World Health Organization for Europe Conference at Trieste in 1984 identified, large mental hospitals are deplored and, indeed, declared outdated, but governments—often understandably in the present economic climate—withhold the funding to permit responsible movement of institutional care to extramural or ambulatory clinical alternatives. Such administrative equivocation can compound apparent lack of credibility of psychiatrists.

Doctors remember that Osler enjoined them to employ new

remedies when these are effective and, more importantly, to abandon cherished remedies if they are proven to be dangerous or ineffective. Insulin coma therapy and the routine prescription of anti-parkinsonian drugs are two examples of established practice and ritual being abandoned in response to well-documented scientific evidence. Zealous recourse to ECT or a routinised intensive psychotherapy approach might yet suffer a similar fate.

The qualities necessary for coping with this range of stressful relationships with patients and colleagues, and the complexities of treatment and care, characterise some psychiatrists and not others. The psychiatrist requires a capacity for detachment, yet a maturity which provides warmth and support at the same time as he recognises, controls or anticipates inappropriate emotional entanglement and developments. The possession of such professional complexity is in part a function of maturity, but derives mainly from personality and experience, and usually requires a stable and satisfying personal emotional life. On the whole, previous behaviour is the best predictor of the expectation of such maturity but training and supervision can contribute to its attainment.

Except with reference to the negative weight accorded to authoritarianism as a personality trait, the exercise of authority finds little reference in the literature. Given the occasional need for the use of compulsory powers in admission or treatment, the treatment of offenders or others who require management in secure conditions, the supervision of patients subject to legal orders, the requirement to exercise authority with patients subject to legal orders, and the need to exercise authority in some clinical and administrative situations, this failure to refer to the capacity to exercise authority does appear to be an important omission. The ability to use authority without authoritarianism and a capacity for decisiveness yet ability to tolerate doubt and uncertainty, as well as a readiness to facilitate self-determination and consensus among colleagues, would seem to be valuable attributes for a psychiatrist.

Professional attributes

In considering the desirable attributes of the psychiatrist proper attention must be paid to the separate domains of knowledge, skills and attitudes. The required knowledge is detailed elsewhere. Special importance attaches to that basic to all medical practice, together with a more detailed knowledge of drugs and medical conditions which commonly present with or influence psychiatric symptoms. Also necessary is a knowledge of the skills and services brought to the joint clinical task by related professions. The skills of the psychiatrist himself may be divided into clinical, therapeutic, teaching and ad-

ministrative abilities. Clinical skills are acquired through training and their presence assessed by formal examinations, whereas therapeutic skills need to be assessed by supervision or observation of transactions with patients.

It is now generally accepted that all psychiatrists need to have teaching skills not only for undergraduate and postgraduate medical teaching but in order to contribute to the teaching of other professionals both within the clinical team and in the wider community. In addition administrative skills are now regarded as essential to all psychiatrists because few can avoid responsibility for some areas of administration.

Superior intelligence, mentioned in Table 1, would be generally recognised as desirable in a specialty which required a rigorous postgraduate training; but it is of interest that some American training programmes specifically prefer candidates from the lower cognitive segment of their applicants on the grounds that they will be less likely to over-intellectualise. This is less plausible than the more general view that entrants to medical school should be from all social backgrounds, geographical regions and include minority groups.

Selection for medical school in the United Kingdom is now largely based on academic achievement at A level and despite some liberalisation of entry requirements, still draws almost exclusively upon science sixth forms. Students with high grades in science tend to have narrower interests, be less adaptable and feel less comfortable with other people. Those interested in a career in psychiatry score highly in personality dimensions such as reflectiveness (thinking-introversion, reflecting an interest in abstract ideas rather than ideas with practical application), and also in complexity of thinking, which is the capacity to tolerate ambiguities (Walton, 1969).

Exceptionally strong reversal in the traditional selection on the basis of science-based pre-medical instruction is now receiving expression. Certain prestigious medical schools (McMaster in Canada is an example) express preparedness to admit applicants who lack this premedical science-bias. The recent report of the Association of American Medical Colleges (1984) expressly opposes discrimination against the humanities in favour of science in premedical college courses.

Since there is a remarkable degree of agreement that although educational institutions emphasise their effect on the people they train, their graduates closely resemble the candidates they admitted at the start; there therefore appears to be strong grounds for re-examining the criteria for entry to medical school. A danger exists that medical schools are selecting with a bias against psychological-mindedness and against 'person' rather than 'science' orientation. An

approach suggested was that a primary screen should exclude those candidates whose science grades are so poor that they will be unable to cope with the scientific foundations of medicine, and the final admission decision then be made on the basis of interview and test findings. Although not an approach at all widely favoured by British psychiatrists at present, it might be possible to select for psychological-mindedness without any lowering of science requirements.

Common sense can be improved, imagination encouraged rather than stifled, and observational ability can certainly be trained. While it has been suggested that psychological-mindedness is comparatively uninfluenced by training and warmth of perception and responsiveness is usually regarded as an aspect of personality, there is some evidence that empathy, warmth and genuineness can be improved by training. Sensitivity, and perhaps intuitiveness to a degree, can be increased by sensitivity group experiences or social skills training.

Of interest as an interpersonal attribute is the characteristic designated as 'likeability' by Holt and Luborsky (1958) who concluded about their findings: 'all of these results make sense if we consider likeableness (in our special meaning) intrinsically related to aptitude to psychiatry . . . psychiatry is an occupation in which the general impression the practitioner makes on other people may be important for his effectiveness'.

Social skills training, it has been mentioned, may have a limited role in improving personal effectiveness and there are certainly means of improving the knowledge and skills called upon by institutional relationships and management.

There have been admitted to membership of the Royal College of Psychiatrists and to the consultant ranks of the National Health Service a significant number of individuals whose verbal facility and use of the written word is so poor as to constitute a major barrier to communication. Some of these have been overseas graduates but the problem is a wider one. It is clear that much greater attention needs to be paid to communication skills in medical schools throughout the world. Many British graduates in all specialties have serious deficits in interviewing and communication skills and these are still neither effectively taught nor properly examined (Sanson-Fisher and others, 1981).

Good psychiatrists can differ greatly in their private and professional roles and attitudes and such diversity is to be welcomed. That notwithstanding, certain attitudes may facilitate or militate against good psychiatric practice. Whether it is wise or even legitimate for those concerned with teaching to attempt consciously to alter the attitudes of their students remains a source of dispute within

the profession, but not at all in medical education generally, where development of appropriate professional attitudes is a recognised teaching challenge (Walton, 1967; Rezler, 1976). Respect for the dignity and integrity of the individual patient and therapeutic optimism become apparent in receptive individuals during their clinical apprenticeship to their teachers and trainers who also possess these qualities. What of students, or indeed teachers, who do not manifest these qualities? Should not professional training be concerned to foster these attributes?

A further comment can be made about extraversion among the desirable traits for a psychiatrist. Walton found the introversion-extraversion continuum to be unrelated to a career interest in psychiatry; Menninger found that introverted, quiet people whose warmth was subdued made the best therapists; but Abel and colleagues found extraverts were rated as more effective. Clearly there is room in psychiatry for individuals on different points of the continuum of sociability.

The remaining elements in the Table require no further comment. Having considered these general attributes of psychiatrists, an attempt should be made to characterise the attributes needed for the major subspecialties of psychiatry. Here general views have to be expressed, other guidelines being absent.

Child psychiatry calls for special knowledge and experience in paediatrics and the care of children. Practitioners need flexibility and skill in the use of non-medical models or approaches. Inevitably the division between normal and abnormal in childhood is more difficult to define, and more borderline, non-medical or educational problems will be dealt with. This involves close work with other professionals and a good knowledge of the educational system. The child psychiatrist must be able to tolerate role uncertainties and subordinate his skills to those of others when appropriate.

The child psychiatrist must be able to empathise with and relate to children and to act as advocate or mediator on their behalf. He should be able to work with families, parents and other caretakers.

It is essential that these attributes and skills should be additional to a competence in general psychiatry, for much of the work of the psychiatrist must be with adults or families.

Psychotherapy There is some evidence that first-year medical students are more empathic than more senior students. The view has been expressed that psychoanalysts can be less empathic after analysis, as a possible consequence of too narrow a training.

Hendrick has complained that psychotherapy suffered from the

inclusion in the ranks of its practitioners during recent years of too many 'more matter-of-fact, common-sense, well adjusted individuals' whereas the innovators and pioneers of the past were 'primarily introspective individuals, inclined to be studious and thoughtful, and tended to be highly individualistic and to limit their social life to clinical and theoretical discussions with colleagues'. Another author claims the psychotherapist needs 'introspectiveness, insight into one's self, creativity, sublimated voyeurism, and a grasp of cultural implications and the relativity of behaviour'.

Psychotherapists who espouse a particular theoretical framework may differ from the generality of psychiatrists. Most practitioners with a special interest in psychotherapy will presumably seek to maintain an eclectic outlook based upon a sound training in general psychiatry.

More evidence is needed about the claim in the subspeciality that certain psychiatrists should be excluded from psychotherapy training and practice, particularly if they are uncomprehending about the inner life of other people.

Forensic psychiatry In addition to the attributes and training of the general psychiatrist the forensic psychiatrist should have the knowledge and ability to work within the penal system and the law. He needs to be able to summarise and express concisely a psychiatric opinion that is comprehensible to non-psychiatrists. He should be able to perform as a witness and mediator and needs an ability to withstand pressure from colleagues, the courts, and the prison system.

Mental handicap calls for a caring capacity rather than a mainly curative perspective. In coping with serious handicap the specialist needs to recognise the permanent nature of disability yet be able to identify and work with the limited assets of his patient. He will need administrative and organisational skills and a breadth of view in conceptualising problems. He should be able to work within an educational and a residential care model. His psychiatric skills are also required in the recognition and treatment of mental illness in the handicapped.

Psychogeriatrics demands enthusiasm, caring and skill in service organisation and administration, and tolerance of chronic disability and multiple pathology; also necessary is patience with and acceptance of the rigidity of aged patients, and their repetitiveness. The psychogeriatrician needs particular skills in working with other agencies and in different environments.

Chronic patient care and rehabilitation requires an ability to balance care and cure, to accept limited objectives and retain therapeutic optimism, and the need to recognise that not all chronic patients can be socially rehabilitated.

Alcoholism and drug abuse The practitioner in alcoholism and addiction must be able to tolerate failure and accept a wide range of life styles in his patients. He must be able to cope with antisocial personality types and behaviours, and he needs particular skill as a mediator.

Research A passionate curiosity is called for and a capacity to focus on a problem to the exclusion of other concerns. A handicap to research is a great interest in clinical practice, for the enticement is to place research in second place. Nevertheless, some clinical experience and commitment is essential to most research in psychiatry. A major problem, which will be returned to, is how to achieve recruitment and training of individuals capable of fundamental biological research related to psychiatry.

Implications

The state of psychiatric practice in the United Kingdom is such that it is appropriate to consider the failures as well as to review the successes. A profile of those now in consultant posts would not provide an ideal specification for future recruitment into the profession; a profession need not necessarily recruit in its own image.

The Royal College of Psychiatrists has approved an accreditation and approval exercise for trainee psychiatrists in general professional training, and the Joint Committee on Higher Psychiatric Training for senior trainees in higher training, which has resulted in a significant improvement in the overall standard of training programmes and hospital services over the whole of the British Isles. The Royal College has provided an examination for admission to the membership, which has secured a minimum level of academic knowledge and clinical competence for new entrants into higher training. These arrangements are now under critical review. Despite such achievements, and the enormous effort which has gone into them, recruitment into psychiatry has been inadequate and the calibre of new entrants into the specialty at consultant rank has been inferior to that in other major specialties. Some unsuited for careers in psychiatry have entered training: the pressure of service commitment has led in the past to unacceptably low standards for admission into training schemes and appointment to consultant rank.

Failures in three areas—recruitment, selection and training—therefore need to be examined.

There has been much discussion about what it is that puts medical students off psychiatry. There is a wide variation in the proportion of students who enter psychiatry from different medical schools and some evidence has emerged that half of those who initially express an interest in psychiatry change their minds by the time of graduation. There is some evidence from the United States that the standards of teaching in psychiatry to medical students are at least partially responsible for this retraction of interest.

In this country some of the differences between schools may be related to effective teaching or the presence of charismatic teachers, but an alternative possibility is the differences in selection policy that operate among medical schools. The numbers overall opting to enter psychiatry are comparatively small.

More students entering medicine who are psychologically minded are needed as potential recruits to psychiatry. It might be argued that, given the large number of candidates with good entry qualifications, an effort should be made to select on the basis of interviews or psychological tests those applicants who offer both high basic sciences A level results and indications of psychological-mindedness in the broadest sense. A further step would be to accept candidates with non-science A levels but sufficient achievement in chemistry to cope with the science aspects of the medical curriculum. Teachers of psychiatry do not respond sympathetically to such an approach, only partly because of the difficulties in identifying the desirable attributes.

With a wider range of potential applicants passing through medical school, and inreasing numbers choosing a career in psychiatry, it would be possible to apply more rigorous selection criteria for entry into psychiatric training. It is important to retain sufficient flexibility to admit unusual or controversial candidates motivated to study psychiatry. A markedly introverted and convergent scientist may fail to meet the requirements for a good clinician, and yet might make fundamental conceptual or laboratory advances in the subject. Given strong interest and motivation on their part, gifted individuals not fitting the standard mould should not be excluded.

One effect of improved recruitment when economic restraint also exists may be to increase the difficulties experienced by women who seek to train on a part-time basis. There has been little consideration of the sex-related characteristics, if any, of the psychiatrist, and women have come to form a high proportion of the 'mature' entrants to psychiatry in recent years.

In general, however, sufficient desirable attributes can now be

identified to permit positive selection for entry into training, and the stipulation of certain negative attributes which may constitute a bar. There is still some uncertainty regarding the extent to which certain of these attributes can be modified by training. There is increasing evidence, however, that training can modify undesirable attributes or facilitate the development of desirable ones which are lacking.

There are, however, some absolute bars to entry and these should include marked emotional coldness with an inability to form relationships, a schizophrenic defect state, marked eccentricity, and extreme degrees of some personality traits such as irritability, gross social withdrawal and excessive detachment.

In a profession which lays great emphasis upon the uniqueness of the individual, there is much too little evidence of individualisation of training programmes. Careful selection for entry needs to be associated with a readiness to reject trainees who fail to maintain progress. Under the present system of training with a multiplicity of supervisors who do not always provide appropriate role models, and the one-to-one nature of most clinical transactions, it is not easy to identify and monitor adverse characteristics or deficiencies. The situation is further complicated by the fact that trainees can move between different programmes without continuity of supervision.

Training should be tailored to the individual with placements selected according to training need. Empathy or sensitivity training is not something to be undertaken merely as a Friday morning seminar or a day release course, but requires a carefully planned and monitored programme for a particular individual. Such a training programme would require a change in the current organisation of postgraduate training and in the contract of employment of trainees.

Empathy—or relationship skills

There does now seem to be empirical evidence to support the belief that many important outcomes of medical practice are dependent on the interpersonal skills, and particularly the empathic skills of the practitioner (Rezler and Flaherty, 1985). There are three sorts of studies which are relevant: (1) studies of consultation in general medicine rather than psychiatry as such; (2) studies of outcome of psychotherapy; and (3) studies of medical students and doctors in training.

1 Non-psychiatric studies

Several studies have investigated how the doctor's behaviour affects the outcome of consultations in general practice and in paediatrics. These studies typically assume that the doctor needs two important

skills: (a) to be able to provide conditions in a consultation in which the patient can accurately transmit information about his history, symptoms, worries, and so on; (b) to be able to 'decode' non-verbal and verbal signals provided by patients (that is, sensitivity to interpersonal cues). Although these studies are not of psychiatric consultations it could be argued that the same skills are even more important in psychiatric settings.

Korsch and Negrete (1972) investigated patients' satisfaction with consultations in paediatrics and whether or not they complied with medical advice. General findings were that satisfaction and compliance depended on the social behaviour (rather than technical competence) of the doctor. In brief, doctors who were friendly in their social style or who elicited patients' worries and expectations (empathy) produced higher satisfaction and compliance. Empathy and warmth seem to be the critical behaviours.

Di Matteo (1979, 1980) showed in several studies that how satisfied patients were with general practitioners depended on the doctor's sensitivity to non-verbal cues. Unsuccessful doctors fail to notice and wrongly interpret non-verbal cues from patients.

2 *Outcome of psychotherapy*

In early work, Carl Rogers suggested that three therapist attributes were necessary and often sufficient conditions for change in psychotherapy: (1) accurate empathy; (2) non-possessive warmth; and (3) genuineness (congruence).

Traux and Carkhuff (1967) went on to argue that therapist traits were better predictors of outcome than the theoretical approach used (psychoanalytic or behavioural or client-centred therapy) and devised scales to measure these variables. There is still some controversy as to the importance of such effects. Truax and Carkhuff have evolved elaborate and detailed training programmes to raise the level of empathy, warmth and genuineness in therapy sessions. Poole and Sanson-Fisher (1979) have reported an empathy training programme for medical students.

Current developments

There is a current move away from viewing empathy philosophically. The move is towards direct study of the clinician's attitudes towards patients, specifying the verbal and non-verbal components of empathic styles so that they can be learned. Currently used programmes emphasise specific empathic skills such as (1) use of open-ended questions, (2) non-divertive reflection, (3) summarising, (4) attending behaviour, (5) eye-contact and so on. There is good reason to

think that many of these specific behaviours are trainable (Argyle, 1975).

There seems to be some evidence that interpersonal skills such as empathy and sensitivity to cues affect outcome of consultations and of formal therapy. Potential psychiatrists, ought, perhaps, to show a willingness for their empathic behaviour to be monitored, with readiness to undergo training in this area where indicated.

Summary

An attempt has been made to review an uncertain area where data is seriously lacking. The reasons why psychiatry is chosen as a specialty have been considered, the morbidity and vulnerability among those recruited has been noted, and the implications of the high proportion of women applicants and overseas trainees entering psychiatry have been examined. Regarding the last, there is some suggestion that many overseas trainees drift into psychiatry rather than choose it and this may be a factor contributing to their vulnerability.

The intense nature of treatment relations has been stressed. Comment is made of the uncertainty, under contemporary circumstances, of where ultimate clinical responsibility lies: the psychiatrist is trained to be responsible for decisions and actions but this does not always apply with non-medical team leaders. This raises the burning issue, when attributes of psychiatrists are under consideration, of the relationships which psychiatrists have with their non-psychiatric colleagues and the implications of this authority.

When the necessary range of skills required is reviewed, the emphasis must perhaps be on common sense and the great importance of the attribute labelled for present purposes as 'likeability'. Training, it has been noted, has an important role in the development of such attributes as empathy.

Consideration of the special needs of the sub-specialties is even more hampered by insufficient evidence. What is clear is that all entrants to the specialties within psychiatry much be competent general psychiatrists.

Failures were identified in three areas: namely, selection, recruitment into the specialty, and psychiatric training. Attention has been given to selection for entry into medical school, and the value to be accorded to school accomplishment in non-science subjects has been emphasised.

EMPHASES

3.1 Present medical school admission policies should be reviewed and modified where needed to avoid relative exclusion of psychologi-

cally-minded applicants. This could be achieved either by using interview and psychological tests to identify such individuals within the range of applicants with acceptable science A levels, or by accepting entrants with non-science A levels but high motivation who successfully qualify themselves in chemistry. The effects of these procedures should be carefully monitored. This emphasis on medical school entry procedure does not receive general endorsement by teachers of psychiatry.

3.2 Greater attention should be paid to the personal qualities of individuals admitted to psychiatric training schemes and more energetic selective recruitment of suitable individuals should be attempted.

3.3 No individual should be admitted to training unless he meets a definite standard in personal qualities, communication skills and previous education.

3.4 Training should be individualised to ensure that a candidate's potential is fully achieved and his range of education and experience is appropriate to the post for which he is training. This training consideration should have clear priority over service needs which must be met by other staffing arrangements.

3.5 There should be clear procedures for review during training and for termination of training where the individual fails to make satisfactory progress after appropriate remedial counselling and training. An appeal procedure would be required following rejection after which an individual would not be permitted to occupy a training post.

3.6 The membership examination and conditions of service of trainees would require some modification to accommodate these recommendations (see Chapter 8).

3.7 The contribution of late or mature entrants into psychiatry needs to be carefully monitored and recruitment policies adjusted accordingly.

4 Academic departments of psychiatry

University departments of psychiatry have an essential role at all stages of training in psychiatry. They are involved in the whole sequence of education and training: behavioural science teaching in the preclinical curriculum; clinical psychiatry teaching to clinical medical students; contributing to the training of general practitioners; and organising and taking part in the postgraduate instruction of future psychiatrists at the general professional and higher levels of training. All these tasks have grown in extent during recent years, as the intake of medical schools has increased, and the academic standards and organisational complexity of postgraduate training schemes have extended. In addition to these medical education responsibilities, many university departments of psychiatry also take part in the teaching of undergraduate and postgraduate psychologists, and of social workers.

These increasing demands have not been matched by additional resources. Departments of psychiatry vary markedly across Britain in size of staff, accommodation, and provision of funding and other resources. One of the reasons for bringing the Association of University Teachers of Psychiatry into being was to rectify such anomalies: some university departments still lack a chair of psychiatry. Although most departments have had some increase of staff to take account of the greater number of clinical students, this increase has seldom been sufficient to enable the department to undertake the additional teaching (and the extra clinical work that is required to ensure that students see sufficient patients) without a serious erosion in the research activities of their staff. As a result, many lecturers in psychiatry have little more time for research than their teaching hospital senior registrar counterparts who, under the requirements of the Joint Committee on Higher Psychiatric Training, should have two sessions for research each week. Thus, although an academic post may still be attractive to a trainee psychiatrist who wishes to improve his teaching skill, while he carries out some limited research in an academic atmosphere, few of these lecturer posts provide the opportunity for serious research which should be the hallmark of an academic post.

Much the same applies to many of the senior academic posts in university departments of psychiatry. These departments were generally set up in the late 1960s and the 1970s after the major

expansion of universities. They are smaller than older established departments, such as medicine and surgery, and generally contain fewer tenured appointments. This compounds the problems of the lecturer grade referred to which make it difficult to train good candidates for the few senior posts coming available.

The Medical Research Council and the Wellcome Trust, recognising the problems in university medicine generally which have followed government education cuts, have made some useful provisions. Several types of training fellowships have been made available, generally for trainees who have passed the membership examination and who wish to spend between three and five years in research. Awards have also been made at senior lecturer level in an important scheme supported by the Wellcome Trust, and the MRC has a scheme for clinical research professorships for highly gifted research workers. Neither of these senior schemes has, so far, made much contribution to alleviating the staffing problems of university departments of psychiatry, partly because chronic understaffing and lack of resources make it difficult for departments to provide the research base from which such developments must grow.

If departments cannot easily advance to the point at which they can take advantage of these forms of support potentially available, what other possibilities for help exist? Since a major part of the burden on departments arises from their contribution to postgraduate teaching, it is logical to look to the National Health Service. Many regional and district health authorities have been generous in their support of their associated medical schools, particularly in the face of recent cuts in the grants to universities. However, these measures, though welcome, have generally done no more than relieve the worst effects of the cuts: they have not dealt with the fundamental problem.

The fundamental problem would appear to be that there have been many years of under-funding of psychiatric services, with associated difficulties in recruiting staff of high calibre to underprovided services. As a result, postgraduate training in psychiatry started from a lower level than that in most other medical disciplines, and correspondingly more had to be done to improve standards. Also, because some senior staff in psychiatric hospitals had not benefited from a sound academic training in their earlier years, more training had to be undertaken by the university departments, as compared with the contribution required from, say, university departments of medicine to postgraduate training in general medicine in a health service region. The cost of this postgraduate training has never been estimated accurately and, despite references to the matter in the report of the Royal Commission on Medical Education (1968), has never been paid for directly by the NHS. It is true that some health

authorities make a financial contribution to university departments of psychiatry but in general it is in the nature of an *ex gratia* payment rather than a payment for service. Hence it varies from one part of the country to another depending on the generosity—and the resources—of the various health authorities.

Some departments have circumvented these problems by providing postgraduate teaching in the form of a master's degree for which fees can be charged (and reimbursed by the health authorities). However, these arrangements are not possible in every university, and it can be argued that a proliferation of postgraduate degrees of this kind is not the best way of arranging postgraduate education. In any case, these fees, which vary from year to year, do not solve the crucial obstacle, which is the lack of sufficient tenured appointments for the senior academic psychiatrists who are needed to set standards in postgraduate teaching, to take consultant responsibility for clinical services and, most important, to direct the long-term research which is essential if real progress is to be made in psychiatry.

EMPHASES

4.1 University departments of psychiatry are implicated in all stages of education and training in psychiatry.

4.2 The magnitude of their responsibilities in all educational and training sectors has progressively increased.

4.3 Departments vary to an unacceptable extent from one university to another in staffing, accommodation, and resources, and their capacity to provide good clinical services.

4.4 Lecturer posts do not offer adequate opportunity for research.

4.5 Departments of psychiatry, established recently, were never accorded the facilities of long established subjects in the medical school, and their under-staffing and inadequate academic provision urgently need correction.

4.6 Postgraduate training in psychiatry has been developed more recently than in other specialties and the essential contribution to it of university departments of psychiatry calls for improved academic resources.

5 The pre-registration period

Introduction

A medical student is not a trained doctor when he leaves the medical school. He requires postgraduate training to acquire the abilities needed for practice in each of the branches of medicine.

In Britain doctors do not become registered practitioners for a year after leaving medical school. They are granted provisional registration by the General Medical Council (1978), and are required to work as pre-registration house officers, under supervision of the medical school from which they graduated. The pre-registration year had come into some disrepute and a number of objections had been raised about it: the chief is that one year was widely regarded as too short a period before the medical graduate entered his specialty training. A prestigious Committee of Inquiry (GB, Parliament, 1975) confirmed that successful completion of an undergraduate course in medicine should confer only the right to 'restricted registration'; only after what the Committee called 'graduate clinical training' would the young doctor gain the right to full registration.

One of the most controversial of this Committee of Inquiry's recommendations, in the event rejected, was that 'the preregistration period should be extended to two years'. The Committee was seriously critical about the educational defects of the pre-registration period, and advised that universities should provide better and more formal supervision of the posts. 'The pre-registration year cannot be regarded as a satisfactory period of education to deal with the important task of making a clinician of the graduate . . .'

The justification for introducing psychiatry into a pre-registration year must be for educational reasons—to improve that year's training content, to complement the undergraduate curriculum and to prepare doctors better for general professional training and for the later stages of specialisation. It will be proposed that where such psychiatric pre-registration posts in psychiatry are made available, they should not—for the present—be mandatory but an option to be selected. Such an innovation gained support at a recent conference held by the Association for the Study of Medical Education (1983).

2 The arguments for a pre-registration period in psychiatry

Experience in psychiatry in the pre-registration year would broaden the doctor's education: it could act to counterbalance influences which are actively hostile to an interest in psychiatry and patients with psychiatric disorders and which, it has been suggested (but with little evidence) prejudice recruitment to the specialty. The appropriate post would offer training to include:

a. the recognition and treatment of psychiatric emergencies;

b. psychiatric aspects of physical illness;

c. the diagnosis and treatment of 'minor' psychiatric disorders as encountered in general practice and outpatient clinics, with experience in brief psychotherapy and possibly behavioural techniques;

d. liaison with other relevant disciplines, especially social work and clinical psychology.

The post would give the young doctor an opportunity to incorporate more of the undergraduate education he received into the mainstream of clinical experience and to revise knowledge and clinical skills about psychological aspects of management. He would work in an environment less hierarchical than some other disciplines and one which would allow detailed consideration of illness in addition to disease, and about personal experience of patients in addition to medical technology.

It might be that the introduction of the specialty as a pre-registration subject would enhance the status of psychiatry, and also reduce some of the neglect in medicine and surgery of the social and emotional aspects of illness.

3 The arguments against

The introduction of psychiatry into the pre-registration year, certainly if done on a large scale, would be strongly resisted by the medical and surgical specialties, and the realities of medical politics and power would make such a radical reorganisation unlikely. It might also be used as an argument in the curriculum committees of medical schools to reduce the amount of time provided for the teaching of psychiatry.

If psychiatric experience were to be shared with a medical post this would reduce the time spent in general medicine by the young doctor to three months. Many psychiatrists themselves question whether the average trainee entering psychiatry has sufficient experience and grasp of clinical medicine: such a reduction of general medical

experience in the pre-registration programme would further aggravate any such deficiency. If, as an alternative, psychiatry were to be a four-month rotation in its own right, then three very different assignments would mean that clinical experience in this year might lack continuity and be too fragmented, and the development of clinical method, self-confidence, responsibility and professional identity in clinical situations might be impeded. It must also be doubted if, at this level of experience, a four-month posting in psychiatry would be adequate. The time necessarily spent in reorientation would detract from the acquiring of skills, contact with individual patients would be too brief, and difficulty would be experienced by the doctor in becoming incorporated in a multidisciplinary team.

There are other limitations to what might be possible or desirable. All pre-registration posts must, by General Medical Council requirements, provide 'general experience' and be in 'general hospitals'. Thus, only those psychiatric units situated in district general hospitals or other teaching general hospitals would be in the position to provide posts. They could accept only a part of medical school graduates, and even so their resources would be inadequate especially for the necessarily close supervision of new graduates.

4 Alternatives to a mandatory pre-registration period

There is a case for experimentation on a limited scale using a number of different models. One such development might be on the lines of a scheme recently started in Sheffield where three posts have been created with four months each in medicine, surgery and psychiatry: these posts were regarded as suitable for doctors with open minds about their future careers and for those intending to enter general practice. A similar scheme is in operation at Charing Cross Hospital where for six years a pre-registration post has been shared between psychiatry and neurology. Other experimental psychiatric posts might be set up, for example, an attachment to an inpatient district general hospital or a full-time attachment to a liaison psychiatry unit in a general hospital. Such trial schemes would need to be carefully thought out and fully evaluated.

5 The Short report

The Short committee (GB, Parliament, House of Commons, 1981) expressed itself as convinced that organised training programmes are needed, and should consist of one year of 'general clinical' post-registration experience in a field or fields of medicine other than the prime career choice in training. This concept of a pluripotential period of initial training was first recommended by the Royal Com-

mission on Medical Education but has never really been put into effect. The Government has accepted this proposal. On the other hand the Royal College of Psychiatrists has expressed the view that although the concept is desirable it should not be mandatory.

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5.1 All future clinicians should have some experience of psychiatry. This could be achieved in a variety of ways both at pre-and post-registration level.

5.2 The general professional training along the lines recommended in the Short report, even if not mandatory, will become part of the experience of most doctors. A period of six months in psychiatry as an SHO either in psychiatry or the psychiatry specialties would be valuable, for example, for the future general practitioner, paediatrician, geriatrician, general physician, gynaecologist or specialist in physical or community medicine. Psychiatrists in collaboration with colleagues from other relevant branches of medicine should now consider what type of psychiatric experience, and in what setting, other doctors with widely differing needs will require.

5.3 Introduction of a more extensive general professional training period will provide opportunities for offering psychiatric experience for non-psychiatrists, but there is still a good case for setting up a number of pre-registration posts in psychiatry. The details need to be carefully thought out, not the least so that the idea can be found acceptable by colleagues in other specialties. Schemes recently introduced, such as that in Sheffield, described by Seager (Association for the Study of Medical Education, 1983), would require careful evaluation.

5.4 There needs to be well organised contact with psychiatric units and psychiatric practice (especially emergency referrals) in the pre-registration period and subsequent years—especially for those doctors who will not be doing psychiatry during the proposed period of general professional training; this could be best achieved by an improved psychiatric liaison service in general hospitals.

6 General professional training in psychiatry

The term 'general professional training' was used by the Royal Commission on Medical Education (1968) to specify the three years after registration. This period was to involve a planned series of posts, some compulsory and some optional, with many posts suitable for trainees in training for different specialties. All training posts in a region were to be coordinated by a single body. There was also to be a systematic education, much of it involving trainees of several specialties. The Merrison committee (GB, Parliament 1975) found that such general professional training had not been established in the event, and would have been unsatisfactory had it come about. The Committee preferred a division of medical education into undergraduate (four years); graduate clinical training (two years) leading to registration; and specialist leading to accreditation by the GMC.

Present-day general psychiatric training resembles the Royal Commission's ideal in that it lasts three years, is provided in the same geographical area for an individual trainee, and involves a sequence of posts. However the posts are usually in the same institution and there is little mingling with other specialties. The form has been largely determined by the MRCPsych examination and the approval exercise of the Royal College. A rotational training scheme was already in operation at the Maudsley Hospital in the early fifties and in Edinburgh a few years later. The number of similar training schemes has steadily increased as more facilities and more posts have become available.

An operational definition of general psychiatric training in 1981 might be: 'a three year period in posts in psychiatry (and sometimes in certain other disciplines) that make a trainee eligible to take the MRCPsych examination'.

General professional training in other disciplines

The pattern of general professional training varies considerably from one branch of medicine to another. In general surgery, for example, a primary examination in the basic sciences may be taken after a six months casualty appointment, and the final part (FRCS) after a further two years registrarship in surgery, one year of which may include the various surgical specialties. Anaesthetics trainees usually proceed to the final FFARCS four years after registration: they are encouraged to gain experience in medicine before they proceed to

general professional training. In pathology the MRCPath may be completed after four years experience in the specialty and marks the end of training (that is, completion of higher professional training).

Likewise, in community medicine the MFCM marks the end of substantive training: wider preliminary experience in other branches of medicine is usually required, followed by one or two years registrarship (for part 1) and three years as senior registrar during which time a thesis is written for part 2 of the examination.

Trainees in obstetrics and gynaecology not infrequently obtain an FRCS in general surgery as well as training in the specialty itself, which involves a part 1 examination (for which a case book is presented) followed by a clinical part 2.

General physician trainees also complete the MRCP at the end of general professional training, the part 2 including a clinical option in paediatrics. General practioner trainees are now encouraged to undergo wider training through a sequence of hospital posts, and in most areas rotational schemes are already well established.

Strategic aspects of training

The need for a wide range of clinical psychiatric experience in the early years of training has found expression in the establishment of rotational training schemes. The Royal College favours this pattern and detailed advice on form and content were summarised in a report (Royal College of Psychiatrists, 1981). Critics of the pattern have pointed out that the changeover of trainees at intervals varying from 3–12 months may entail penalties. Dislocation of the smooth functioning of clinical service may occur when the care of patients has to be summarily transferred to a new junior. Also there is the problem of allowing sufficient time for a fruitful identification between the trainee and his consultant mentor.

There is further conflict between the maintenance of utmost flexibility in a rotational scheme in order to meet the varying needs of trainees individually and, on the other hand, the adoption of a more rigid pattern to make for greater predictibility of movement and smoother administration.

The Royal Commission on Medical Education (1968) had recommended that general professional training posts should be subject to approval. The Royal College of Psychiatrists has so far been concerned with the approval of hospitals with good library facilities, enough trainees, and a sufficiency of varied clinical experience. This exercise has been essentially concerned with potential. The requirement for individual trainees, set out in the MRCPsych regulations, is three years in an approved hospital, and this usually means in the

same institution (except for the special case of a hospital with an S-grading where approval is limited in range—for example, in child psychiatry or mental handicap—where experience up to a maximum of 18 months only would be valid as part of the required three years).

Perhaps the time is now ripe for moving to approve programmes, that is, a sequence of individually approved posts, some compulsory and some optional, in a hospital or group of hospitals. There might be some posts in a hospital that were approved if an adequate academic course were included (although this would not imply compulsory attendance at lectures or seminars for all trainees). The notion of optional as well as compulsory posts is important, because as much flexibility as possible is essential. The trainee would not be eligible for the award of the MRCPsych until he or she had completed an approved programme. 'Firms' not approved for training would then require non-consultant staff other than SHOs or registrars for service needs and there may be difficulties in realising this because of the current NHS staffing structure.

In order to allow time for experience in the various branches of psychiatry, including child and adolescent psychiatry, mental handicap, psychiatry of old age, psychotherapy, and other special fields, most rotational schemes operate on a three-year cycle. Arrangements for appointing trainees to SHO/registrar posts with a reasonable expectation of a 3½ year duration have been achieved in some centres. The argument has been put forward that this formula, together with the obsessive preoccupation of the trainee with clearing the MRCPsych examination hurdle, has stunted initiative and has militated against research enterprise or study in depth. The College has been urged to allow earlier entry to the membership examination, and if this point were conceded there may be considerable implications for the future patterning of rotational schemes.

To date most psychiatric hospitals and units in the UK and Eire have been granted approval for membership training. The approval exercise was designed as a device for progressively raising the standard of training through repeated visitations. Approved hospitals include: the Maudsley-Bethlem Hospital; large scale rotational schemes involving a university department; isolated psychiatric hospitals; and smaller psychiatric units in district general hospitals. How rigorous is the College prepared to be in its move to elevate standards? Should there be a concentration of training in a smaller number of centres where access to university facilities is easy and where the all-important 'critical mass' of students can be created and, hence, the stimulation and positive feedback so necessary for good training? There are obvious difficulties in effecting such changes, including the problem of staffing 'non-teaching' hospitals; and the

inclinations of consultants who, for various reasons, would like to train juniors even though the setting is far from ideal.

Academic content

The content of 'academic' courses is largely, and their timing almost entirely, determined by the preliminary test and the MRCPsych examination. A more rational scheme therefore depends on changes in the Royal College's examination system.

The current view is that at the beginning of training an introduction to general psychopathology and other basic psychiatric topics (taxonomy, conceptual 'models', and the like) should be emphasised. Short courses in psychology, pharmacology, genetics, and so on, which can conveniently be forgotten after the preliminary test, have little value. Learning should be so arranged that the trainee, at the end of his general training, has a sound grasp of those aspects of so-called basic science that will be important to him throughout his professional career.

Any academic course must consist of a 'core' curriculum, generally accepted by the psychiatric profession and tested in the membership examination. Otherwise differing forms of academic teaching should be encouraged in different centres, provided that the emphasis in on learning and self-education. The academic atmosphere should be designed to encourage research and a spirit of enquiry. Trainees with neither interest in nor aptitude for research might be encouraged to undertake some sort of 'study-in-depth' and to appreciate that a scholarly approach is as appropriate in the clinic as in the classroom.

Assessment of training

The MRCPsych examination

The aims of this examination are twofold, firstly to assess the basic psychiatric knowledge and clinical skills of trainees, and secondly to promote adequate training.

According to a recent survey of trainees, the present membership examination with modifications can achieve the first aim. The second aim, however, particularly the adequacy of supervision given by individual consultants, is proving more difficult to achieve. The Collegiate Trainees' Committee recommends the following modifications to the present examination:

a. The preliminary test should examine both basic sciences and theoretical knowledge relevant to clinical skills. The long essay should be abolished in favour of short answer questions. The multiple

choice examination should remain but have a clinical in addition to a basic science component.

b. In the membership examination the interviewing skills of the candidate should be assessed by videotape, audiotape or by direct observation.

c. The present membership examination should be augmented by the use of videotaped short cases followed by short answer questions.

d. The present feedback given to candidates about their examination performance needs to be extended.

e. Extensive guidance should be provided for examiners who should be carefully chosen and assessed for their skills in examining.

Diploma in clinical psychiatry

Establishment of a new, additional College diploma requires careful consideration. A possible model would be a Diploma of Clinical Psychiatry (DCPsych) to be taken after one year in an approved psychiatric post at least six months of which should be in acute general psychiatry. Such a diploma might find favour with GP trainees, trainees in other specialties, psychiatric trainees undecided on a career in psychiatry, psychiatric trainees unable to sit or to pass the MRCPsych examination, clinical assistants, hospital practitioners and part-time trainees. The diploma could be identical to the revised preliminary test, or may contain additional sections, for example, presentation of a casebook or an audiotape of an interview personally carried out.

The role of continuous assessment

The introduction of continuous assessment as an examination procedure during training has been considered frequently. To be a valid method, continuous assessment would need to be formalised. Possibilities range from a record of performance in posts held to a structured questionnaire issued by the College to be filled in jointly between psychiatric tutor and trainee. The trainee should then have the opportunity to comment on the adequacy of training, in addition to the tutor being able to comment on the performance of the trainee.

Adjustment to psychiatry

Compared to America, psychiatrists in Britain have paid little attention to trainees' adjustment. A study of the 'socialisation of psychiatrists' highlights two problem areas:

a. Confusions resulting from the fragmented nature of experience provided by rotational training schemes.

b. The nature of multidisciplinary teamwork where the rules of division of labour are rarely explicit.

Other problems of adjustment include:

i. The relative absence often of clear diagnostic landmarks with the need to tolerate high degrees of uncertainty.

ii. The confusion which can arise from working with different 'models' of illness and with the para-psychiatric disciplines.

iii. Reactions to the complexity and poignancy of many psychiatric problems with which the trainee necessarily has to empathise, when unresolved feelings may lead to unhelpful over-involvement or detached over-attention to theory. Genuine empathy accompanied by realistic objectivity is a difficult balance to maintain in the face of perplexing symptoms.

Adjustment for overseas trainees may be still more difficult because of relative cultural, social and linguistic isolation.

Failure of adjustment on the part of trainees may result in:

i. The loss of potentially good psychiatrists to alternative disciplines.

ii. A retreat from patients into impersonal and rigid models of practice.

iii. Inability to cope leading to neurotic breakdown, or more serious problems.

A trainee must be given the necessary help to adjust. He must recognise the difference between 'learning about psychiatry' and 'becoming a psychiatrist'.

He must realise his own limitations in being able to help in many situations. Above all he must learn a healthy introspection: an ability to keep in touch with his feelings without their distorting his judgment.

Provision for non-consultant grades and part-time trainees

The rigorous control of numbers of trainee grade posts in recent years has led to the massive introduction of clinical assistant sessions into the psychiatric service. A considerable amount of the service load may now be carried by clinical assistants, yet there seems to be very

little provision for their psychiatric training. No previous psychiatric experience is required, and apart from two weeks study leave per year, they cannot obtain financial support to attend relevant lectures and courses on a regular basis. It seems, thus, that formal training is restricted to those who aspire to become consultants, yet it is a major anomaly that so much service provision should depend upon individuals who are financially excluded from such training. If clinical standards are to be improved, ways of supporting and encouraging the training of clinical assistants should be explored further, particularly as some of them proceed to become medical assistants who can enjoy considerable clinical autonomy. Clinical assistants are not necessarily also general practitioners: they may enter psychiatry from many other areas of medicine, and they can be a rich source of clinical skill upon which psychiatry has come to rely heavily.

The introduction of part-time general professional training has been a welcome development which has made it possible for many doctors with domestic commitments to resume training when otherwise they would have been unable to do so. Certain anomalies are, however, beginning to arise as a result of this scheme. It is important that part-time trainees should obtain comprehensive clinical experience and there should be regular review of their programmes in order to ensure that adequate rotation through clinical psychiatry posts occurs. Full-time trainees may question the less formal appointment and promotion procedures adopted in the case of their part-time colleagues, as well as the poorly defined duration of tenure of part-time posts. The part-time training scheme is likely to produce serious anomalies and inconsistencies in relation to full-time training, and there is a need for more adequate guidelines regarding its implementation.

Training for general practitioners

Although only marginally relevant to the issue of recruitment to psychiatry this topic is mentioned because the arrangements for training are intimately bound up with those for junior psychiatrists. Many GP vocational training schemes now have a need for SHO posts in psychiatric settings. GP trainees spend about six months usually in acute units or busy day hospitals. The posts have been taken from the existing pool of the psychiatric SHO establishment.

A reciprocal arrangement which has hardly been explored is the possibility of offering selected junior psychiatrists an attachment in the primary care field to gain experience akin to that of general practitioner trainees, rather than as psychiatrists working in this setting.

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General professional training departs in practice from the Royal Commission (1968) model in being largely confined to single specialties. In psychiatry the form and content has been strongly influenced by the requirements of the MRCPsych examination and by the approval exercise. There is currently a move, reviewed under the aegis of the GMC, to make the GPT period less specialised.

6.1 The Royal College should now move from approval of hospitals to that of programmes of training involving particular posts with an associated academic course.

6.2 Concentration of SHO/registrar training into fewer centres is probably desirable, though the difficulties of implementing this move are acknowledged.

6.3 The possibility of allowing entrance to the MRCPsych examination after two years in psychiatric training (even in the absence of approved experience in medicine, paediatrics, and so on) should be explored.

6.4 The preliminary test should examine both basic sciences and theoretical knowledge relevant to clinical skills.

6.5 In the membership examination the following developments should be explored: alternative methods of assessing interviewing skills; video recordings of short cases; better feedback to candidates; and improved guidance to examiners.

6.6 The introduction of a new diploma in clinical psychiatry requiring one year's training should be actively pursued.

6.7 The psychiatric tutor is of cardinal importance in facilitating the adjustment of trainees to the subject, and his own resources should be augmented.

6.8 The education needs of non-trainee non-consultants and of part-time trainees should receive attention.

6.9 Special care must be exercised in the selection, training and tutoring of the large number of doctors from overseas who enter psychiatry (see Chapter 14).

7 Educational objectives during general professional training

Much evidence has now accumulated that a teaching programme is most effective when the required change in the performance of the trainee is made explicit (Bloom, 1956). In order to express educational intent as precisely as possible it has generally come to be defined in terms of 'goals' and 'objectives', commonly adopting the terminology proposed by Mager (1962). Thus an educational goal is a general aim, an example of which may be: 'The trainee should learn how to utilise the clinical information he has obtained from his patient so as to make a correct assessment and take appropriate action'. For each goal, appropriate objectives are written which will stipulate the criteria of the trainee's performance when he has achieved the goal. In the example given, the main objective might be that 'the trainee will write a formulation demonstrating that he can make use of the clinical information he has collected in order to reach a number of subsidiary objectives: (a) establish the most likely diagnosis; (b) identify possible causal factors; (c) express a psychological understanding of the illness; (d) devise a plan of treatment; and (e) assess the prognosis'.

It is useful to determine precise objectives because (a) they can be readily translated into instructions to trainees and teachers so that the former know what they are expected to learn and the latter what they must teach, and (b) specification of objectives also points to various forms of assessment ranging from informal 'feedback' from teacher to trainee, to an examination designed with the educational objectives in mind.

Educational goals and objectives should appropriately be defined along these lines whenever it appears reasonable to do so. In general psychiatry the methods can best be applied to the attainment of clinical skills, the acquisition of theoretical knowledge, and the ability to review the literature and conduct research. It is more difficult to follow this approach when the educational aims are subtler, as when encouraging the trainee to acquire those professional characteristics (for example, attitudes of mind) which distinguish him from other physicians. Initially, then, the psychiatrist's approach to his subject is discussed in terms of broad aims only.

The psychiatrist's approach to his subject

Aubrey Lewis (1970) was well aware of the dilemma of the psychiatrist who has to reconcile a clinical scientific approach on one hand with empathic awareness of his patient's subjective experiences on the other. It is appropriate to quote more fully from his contribution to a previous conference on postgraduate psychiatric education (Lewis, 1970):

> 'The psychiatrist must combine attitudes of mind which seem incompatible, namely, critical scepticism and receptive alertness. Education should cultivate in him a habitual balance in his emotional response to the daily material presented by psychiatry in practice, as well as balance between his judgment of ideas and information, and balance between scientific and intuitive appraisal.'

This statement may be criticised for not indicating clearly how the attainment of its expressed goal in individual trainees is to be assessed. On the other hand most experienced psychiatrists will recognise what Lewis meant, from having encountered themselves the pull of nearly incompatible intellectual requirements in the course of their clinical practice. Those who knew Aubrey Lewis might be surprised that such an analysis should come from him, a teacher renowned for his searching scepticism and objectivity. It is indeed striking that he should have stressed the need for the psychiatrist to become empathic to his patients' subjective experiences, and to reconcile 'intuitive appraisal and scientific objectivity'.

A few additional examples may be put forward of the methods of thought which distinguish the psychiatrist's clinical practice from that of other physicians.

The multidimensional view of psychiatric disorder

The exercise of assigning a psychiatric patient into a diagnostic category is generally of limited value in comparison with the central importance of diagnosis in other fields of medical practice. This is partly because of the complexity of psychiatric disorder and the fallibility of systems of classification. Even more important, however, is the individual nature of a psychiatric disorder, moulded as it usually is to the patient's personality, his previous life experiences and his social environment. Thus it is of benefit for the trainee to acquire a multidimensional view of the causality of psychiatric disorders, accepting that several adverse factors—psychological, social and biological in origin—may interact in causing the patient's disturb-

ance. The trainee learns to recognise pathoplastic influences derived from his patient's personality and his culture. Although it is difficult to express this broad goal in terms of discrete objectives, there are educational consequences to the fostering of such an approach to psychiatric practice. These include an emphasis on studying the patient's individual character and symptomatology (as in Jaspers' (1963) biographical method) rather than relying simply on a list of depersonalised symptoms such as feature in textbooks or in diagnostic instruments, for example, the glossary of the Present State Examination (Wing and others, 1974). It follows, moreover, that the trainee is encouraged to learn a great deal about the individual characteristics of his patient by interviewing reliable informants, and searching for evidence that earlier life events or biological factors might have formed his personality or determined his illness.

The eclectic approach to treatment

Related also to the individual nature of the patient's psychiatric disorder is the need to adopt an eclectic approach to clinical management. The trainee is encouraged to devise a plan of treatment which is tailored to his patient's needs, combining methods deemed to be beneficial, and discarding others judged to be inappropriate in his case. False antitheses between physical and psychological methods of treatment are to be avoided. Because a general management of his patient may be more important than specific therapeutic methods, the trainee psychiatrist should learn to collaborate with members of other professions, of whom the most important are nurses, social workers, psychologists and occupational therapists (see Chapter 17). In the community, the contributions of general practitioners, social workers and voluntary agencies may also assume great importance. Thus the eclectic approach to treatment requires that the trainee is helped to devise ways of achieving an optimal integration of treatment methods, and encouraged to respect the contributions of other professions allied to psychiatry.

Attitudes to moral issues

The trainee psychiatrist may also need help in coming to terms with clinical issues which have a moral aspect. The psychiatrist, perhaps more than other doctors, is often confronted by deviations of behaviour which may be viewed as moral lapses (for example, lawbreakers, sexual deviants, alcoholics) or crimes. Psychiatrists are usually ill at ease in grappling with such issues and will prefer the pragmatic approach of regarding moral judgments as irrelevant to

their task of better understanding deviant behaviour and modifying it by means of psychological methods.

The trainee also requires to utilise constructively the emotional interaction occurring between him and his patient, and he may need support when he discovers that some of his patients are ungrateful or frankly hostile. Although the trainee will be fully aware of the stigma that mental illness carries for his patients, he may still need help in avoiding his own rejection of mentally handicapped or deteriorated patients. Another form of patient rejection may arise through invidious distinctions made between 'psychiatric' and 'social' problems, whereby the former are deemed eligible for medical treatment whereas the latter qualify only for other methods of care.

A particular clinical problem with moral issues frequently confronting the psychiatrist is that of the compulsory admission and treatment of patients. He must attempt to strike a balance between respect for his patient's wishes and responsibility for his welfare when insight and cooperation are diminished. This dilemma arises in the case of suicidal or self-injuring patients, or with those who endanger themselves through neglect. It may be necessary in some instances to deprive patients of their liberty in order to ensure their safety or compel them to receive treatment. The trainee psychiatrist needs to develop his own views regarding these extreme measures which appear to run counter to his prime duty towards his patients. He will learn how to obtain the cooperation of disturbed patients by skilful management so that they alter their attitude and come to accept treatment. By learning to mobilise resources for patient care outside hospital he will reduce the need for compulsory admissions when his attempts at persuasion meet with failure.

The value to the trainee of developing a sense of enquiry which will help him solve novel clinical problems has already been mentioned. This sense of curiosity will lead him to pursue broad enquiries, ranging from discussions with colleagues and searches of the literature, to clinical researches aimed at increasing his own knowledge and perhaps adding to the existing body of knowledge. The trainee may also be encouraged to teach so that he may in turn help clinical colleagues increase their knowledge and skills.

The educational environment

Among desirable attitudes to be fostered in a trainee is one of generosity in contributing to the endeavours of his own medical school and hospital. He will thus help to enliven the intellectual and educational climate of his teaching institution: 'The atmosphere of lively curiosity, serious and sustained enquiry, intellectual integrity

and eager, well-informed, penetrating discussion may be of crucial importance', as Lewis (1961) put it. Trainees in psychiatry will also be encouraged to contribute actively to the work of the Royal College of Psychiatrists, thereby raising the educational standards of the profession and seeking opportunities to improve the quality of care for psychiatric patients.

This discussion on the acquisition by trainees of appropriate mental attitudes and intellectual approaches may appear to differ substantially from the delineation of precise educational objectives, which forms the remainder of this chapter. In this section it has not been possible to achieve a similar degree of precision. Yet it may be argued that broad goals may also be translated into useful educational precepts, trainees learning from the example provided by their teachers, who in turn assess their success from a personal knowledge of their trainees and their attainments.

The need for educational objectives in postgraduate psychiatry

A working party on the topic of educational objectives in postgraduate psychiatry (Hill and others, in Russell and Walton, 1970) divided postgraduate psychiatric training into the broad categories of knowledge, clinical skills and attitudes; each was described with varying degrees of detail forming a type of syllabus for postgraduate psychiatry. During the last decade, educational objectives have been defined more precisely so that a more rigorous concept of measurement can be introduced into the educational process.

In general medicine the teaching at undergraduate level has been arraigned for lacking clear educational objectives. This has been given as the reason why medical students can pass through a well-recognised undergraduate course and still be unable to communicate well with their patients or take a proper history, and why they use both laboratory tests and drugs without due regard for their efficacy or their cost.

The growing recognition of the importance of detailed educational objectives led Walton (1977) to explain to the education committee of the General Medical Council that 'knowledgeable teachers stopped talking as if a syllabus or a timetable was a sufficient description of a course of instruction. Moreover, it became accepted among cognoscenti that only when educational objectives are specified is it possible rationally to select the appropriate teaching method and devise the relevant examination or other assessment procedures'.

Evidence that postgraduate psychiatry training lacks clear educational objectives

Over the last decade the Royal College of Psychiatrists has made strenuous effort to improve the standard of postgraduate training. Sadly, however, it has not been validated by any improvement in the pass rate of the MRCPsych examination. A student may spend three years in a recognised training programme but emerge deficient in the basic clinical skills of his subject. These deficiencies come to light in the MRCPsych examination but such deficiences as their inability to list correct headings for the mental state examination have been detected by other trainees (APIT, 1979).

It is therefore worth considering whether more clearly-defined educational objectives should be established for postgraduate psychiatry. Examination of the present stated aims shows them to be expressed in very general terms. For instance, the aims of postgraduate training quoted together with the criteria for approval of a training scheme are 'achieving the highest possible standard of psychiatric practice in the fullest meaning of the term'.

The educational programme for trainees in psychiatry lists what at first sight seem to be more detailed objectives, but in fact are no more than course descriptions:

1 The teacher will aim at inculcating the principles of history-taking, physical and mental examination of the patient, diagnostic formulation, patient treatment and rehabilitation, including physical and psychotherapeutic methods and the use of social services.

2 Attendance at clinical case conferences, a minimum of 25 each year.

3 Participation in seminars and/or journal clubs (at least 10 per year).

4 When caring for outpatients the trainee will be taught how to ensure continuing care for his patients.

5 Courses in clinical psychology should be provided.

6 Individual and group psychotherapy should be carried out under the supervision of psychotherapists.

These objectives are inadequate for two reasons. First, the individual items are inadequately defined. Research into how well clinical skills are taught has found that the individual skills are not precisely defined (Creed and Murray, 1981). For example, little agreement was found as to what constitutes a diagnostic formulation in an enquiry reported

by the Royal College of Psychiatrists in 1980. Definition of clinical skills is of course possible; at undergraduate level, in fact, psychiatry has been more successful than many other medical specialties in specifying such definitions.

GOALS AND OBJECTIVES

A. Broad Goals

The following are appropriate goals for a three-year postgraduate training programme in psychiatry for SHOs, registrars and clinical assistants. At the end of the course trainees should be able to do the following:

1 To collect, record and communicate clinical information (that is, the history from patients and informants, the patient's mental and physical state and the results of social, psychological and laboratory investigations) in a thorough and reliable manner.

2 To use such information to make a diagnosis, to define factors of aetiological importance, to understand the patient as an individual, to draw up a treatment plan and communicate this with others involved in the care of the patient.

3 To demonstrate the following treatment and management skills:

a. enlist the cooperation and trust of nearly all patients;

b. enlist the cooperation and trust of patients' friends or relatives;

c. enlist the help of social agencies when appropriate;

d. prescribe physical treatments appropriately;

e. manage psychiatric emergencies;

f. work in a multidisciplinary team;

g. use basic psychotherapeutic skills;

h. write a report on a patient;

i. employ an eclectic approach;

j. monitor response to treatment.

4 To acquire basic theoretical knowledge.

5 a. To evaluate critically an area of knowledge;

b. to communicate such an evaluation to others, for example, an audience.

6 To supervise.

7 To conduct research under supervision.

Goals 1–5 are a basic minimum which every trainee must achieve.

Goals 6–7 are examples of important goals which trainees should select in addition to the basic goals. It is expected that in addition to the basic objectives, many trainees will select a variety of individual interests which may only be defined and assessed by themselves. This present discussion is concerned with the essential objectives.

B. Objectives for each goal

Goal 1: To collect, record and communicate clinical information in a thorough and reliable manner

Objectives: The trainee will demonstrate his ability to collect, record and communicate clinical information in the following ways:

a. By obtaining histories in the recognised and standardised form.

b. By recording these histories under suitable headings such as those suggested in (a).

c. By checking the accuracy of those parts of the history which are crucial to diagnosis or management by asking other informants (friends, relatives, employers).

d. By detecting and describing the principal abnormalities in the mental state examination.

e. Important information (for example, delusions, hallucinations, thought disorder, obsessional ideas) will be recorded in the patient's own words.

f. Simple tests of cognitive function will be recorded for most patients with additional tests when abnormalities are suspected.

g. The patient's attitude to his illness and its treatment should be recorded including, when relevant, contradictory statements illustrating, for example, conflict or denial.

Assessment of the attainment of these objectives is made by the registrar's consultant at case conferences and ward rounds.

General medical skills needed for physical examination, the management of medical emergencies and the investigation of medical conditions related to psychiatry (for example, neurological and endocrine disorders) are required.

Goal 2 (the formulation): To be able to use clinical information to make a diagnosis, to define factors of aetiological importance, to understand the patient as an individual and to draw up a treatment plan

Objectives: The trainee will demonstrate his ability to use clinical information in the following ways:

a. For every patient the trainee should be able to record the likely diagnosis or, where relevant, the differential diagnosis. This list may differ from the consultant's, but the trainee should be able to use his clinical information to justify his diagnosis by reference to recent textbooks or original articles.

b. The trainee should list any environmental factors (life events, family interactions) or physical conditions, for example, endocrine disorders which may have precipitated the illness and any constitutional factors (family history or premorbid personality) which might be predisposing factors.

c. Where appropriate (especially for neurotic patients), the trainee should record psychological understanding of some aspects of the patient's illness.

d. For all patients a practical course of management should be outlined; this should offer some help for the main problems which the patient manifests.

e. For all patients an assessment of prognosis should be given.

The assessment of these skills is best made by the trainee's consultant at case conferences. The trainee's conclusions may differ from those of his consultant. However the trainee should be able to give reasons for his conclusions based upon his clinical information and knowledge.

*Goal 3: To demonstrate the following treatment and management skills**

Goal 3a To enlist the cooperation and trust of nearly all patients
A trainee reports some reasonable progress in pursuit of treatment

* None of these can be satisfactorily assessed or defined in the traditional 'case presentation' at ward round or clinical examination. Some form of in-course assessment is required if these goals are considered essential.

goals. That is, the doctor and patient would agree upon some common aim (for example, a rehabilitation programme) and nearly all patients would be able to make some progress (however slight) towards that aim.*

Goal 3b To enlist the cooperation and trust of a patient's friends or relatives
A trainee reports upon a series of meetings with friends or family in which there appeared to be some agreement to modify the way friends or family reacted to the patient.*

Goal 3c To enlist the help of social agencies when appropriate
A consultant can assess the 'closeness of fit' between the social needs of his patients and the social provisions made for them by the registrar in collaboration with the social agencies. (Available resources may vary from place to place and from one specialty to another but a consultant should notice a problem in this area very quickly.)

Goal 3d To prescribe physical treatment appropriately
A trainee demonstrates that he could record reasons for using any drug or ECT and evidence of appropriate monitoring for wanted and unwanted effects of that treatment. Assessment of these objectives could best be made by a registrar's consultant.

Goal 3e To manage psychiatric emergencies
Including violence, attempted suicide and the appropriate use of the Mental Health Act.

Goal 3f To work in a multidisciplinary team
Definition of objectives may not be necessary here as it would usually be clear when there was a problem with 3e or 3f. Assessment of 3e might best be made by a ward sister and of 3f by the multidisciplinary team. However a consultant could assess 3e and 3f also.

Goal 3g To use basic psychotherapeutic skills (Level 2, Cawley, 1977). A trainee would, when relevant:

i. record an understanding of the meaning of aspects of the patient's illness or of his role within the family;
ii. communicate this to the patients and where relevant to the family;
iii. modify the management of the patient accordingly.

Goal 3h To write a report on a patient (for a GP, for example)
A trainee should write a concise summary of a clinical case, free of

*The assessment of these objectives might be facilitated by use of videotape.

jargon, and containing the information of practical value to the recipient (for example, a GP, second opinion, or the court).

Goal 3i To employ an eclectic approach to management
A trainee would use different models of mental illness and differing types of treatment depending upon their relevance to the individual patient. Often a trainee would use different approaches with an individual patient.

Goal 3j To monitor response to treatment
The trainee will record in the continuation notes an objective account of the patient's response to treatment. This will include mention of all treatment modalities employed (including family interviews, social, nursing and occupational therapy work) together with a record of the wanted and unwanted effects of these.

Goal 4: To acquire basic theoretical knowledge

Trainees are expected to acquire sufficient background knowledge

a. to achieve the above goals, and

b. to pass a standard qualifying examination in psychiatry.

Goal 5a: To evaluate critically an area of knowledge

Objectives: the trainee would

a. make a brief and ordered summary of the subject (or paper) in question at a seminar or journal club;

b. evaluate the different aspects of a research study (for example, formulation of hypothesis, test of hypothesis, selection of test and control groups, experimental manipulations, measures, statistics);

c. evaluate the quality of the study;

d. draw conclusions from conflicting data or opinions.

The teacher responsible for the seminar or journal club could assess these abilities.

Goal 5b: To communicate such an evaluation to an audience

An effective communication would be clear, ordered and with appropriate detail, explanation and use of visual aids. It should interest the audience and provoke discussion.

Only the audience would know whether or not this goal had been achieved, although the teacher responsible for the seminar could provide an assessment.

Goal 6: To conduct specialised forms of psychological treatment under supervision

For example, to conduct specialised forms of dynamic psychotherapy (Level 3, Cawley, 1977).

Given a patient in supervised individual or group psychotherapy the registrar will:

a. establish and maintain an effective working alliance;

b. perceive and understand defence mechanisms, transference and counter-transference;

c. make appropriate use of interventions such as confrontation and interpretation.

Goal 7: To conduct research under supervision

The research supervisor would provide feedback and assessment on

a. the selection of an important research field;

b. the selection of a testable hypothesis which is worth investigating;

c. the design of a practicable study which would test the hypothesis;

d. the execution, analysis, written preparation and publication of this study.

EMPHASES

The above considerations suggest the following conclusions:

7.1 Most of the basic aims of postgraduate psychiatric training (that is, those aims which every trainee must achieve) can be defined in terms of goals and objectives. Objectives can be formulated in such a way that they are open to assessment.

7.2 All of these objectives can be used by consultants to provide immediate feedback at ward rounds and other case conferences.

7.3 Some of these objectives could be used without modification to increase reliability and validity of the assessments which are used at present (for example, six-monthly report by consultants).

7.4 The more ambitious aims (for example, research and academic excellence) are not amenable to the same approach as they are not goals which must be obtained at a defined level of performance by all trainees.

The exercise of defining educational goals and objectives in psychiatry leads to the following practical recommendations:

a. All psychiatric trainees should be provided with the clearest possible statement of the educational aims of their training programme. Experience shows that this on its own can lead to a striking improvement in the performance of some trainees.

b. Having agreed upon a series of objectives which are essential for all trainees, it follows that the monitoring of the attainment of these objectives is equally essential.

i. The clinical part of the College membership examination could be adapted to assess goals 1 and 2 (gathering of clinical data and the formulation), using the framework of the consultant's assessment scheme (see Appendix, page 86). This would have the advantage of focusing assessment on the most essential objectives. The scheme could also form a basis for increasing the reliability of examiners. Videotapes of clinical examinations could be shown to examiners to help them rate candidates reliably, in much the same way as when undergoing training in the performance of the Present State Examination.

ii. Some objectives (for example, treatment and management skills) can only be judged by in-course assessment. Part III of the consultant's assessment scheme (see Appendix, page 86) is suitable for monitoring the trainee's treatment skills. This could form 'feedback' between the consultant and trainee. It would direct the attention of both towards correcting areas of unsatisfactory performance. The membership examination of the College is not, in its present form, a suitable method of assessing these treatment skills.

c. It is recommended that the Royal College draw up a syllabus of basic theoretical knowledge in psychiatry, so as to give trainees a clear indication of the essentials of their subject.

d. Further work is needed to establish more precisely those goals and objectives in the broader education of psychiatrists, which would lead to the development of mental attitudes and intellectual approaches conducive to advanced levels of psychiatric practice. It is also desirable to identify more clearly the educational components of a programme which encourages the pursuit of clinical research by psychiatric trainees.

APPENDIX: CONSULTANT'S ASSESSMENT

	Cause for concern	*Adequate for stage in rotation*	*Unusually good*
I History (reliably obtained, logically presented)			
Use of informants to confirm essential material			
Identification of symptoms and signs			
Cognitive testing			
Additional assessments, for example, family interviews			
II The formulation (not necessarily the consultant's but logically derived from information in I)			
Diagnosis			
Aetiology			
Treatment plan			
Psychological understanding			
Prognosis			
III Treatment and management skills			
with patients			
with families, and so on			
with social agencies			
with physical treatments			
with psychological treatments			
with psychiatric emergencies			
with multidisciplinary team			
writing of reports			
monitoring of treatment response			
an eclectic approach			

8 The membership examination

The examination for membership of the Royal College of Psychiatrists (the membership examination) is taken after three years of approved training. It is preceded by a 'preliminary test' taken at the end of one year. This preliminary test is mainly concerned with the basic sciences; the membership examination itself is in clinical psychiatry. In its timing, the membership examination differs from professional examinations in certain other countries, for example Australia, in which the corresponding examination for membership of a professional college is taken at the end of training (it is a so-called exit examination). This difference is important to remember when comparing examinations in different countries: for example, it is sometimes said that the standard of the membership examination in the United Kingdom is lower than that of the Australasian membership examination. In fact, the standards are comparable; the United Kingdom examination is designed to examine at a high standard trainees who have completed only three years of a training lasting six or seven years. The Australasian examination tests for a comparable high standard of knowledge and skill at the end of training.

A related point should be kept in mind when considering the purpose and scope of the membership examination. The examination is only one part of the Royal College's work in regulating standards during general professional training. The other part is the inspection of training posts, and this helps to improve the standard of training in clinical skills which are difficult to assess reliably in an examination.

At present the first part of the membership examination is concerned principally with basic sciences; clinical skills are not examined. The second part is an examination in clinical psychiatry. This arrangement has some disadvantages and the structure (and content) of the examination is being reviewed, at the time of writing, by a committee of the Royal College of Psychiatrists. These problems will be considered in turn under the following headings: the preliminary test; basic sciences and the membership examination; methods for examining clinical skills; information for candidates who fail; training for examiners; and the timing of the examination.

The preliminary test

Candidates who fail to pass this test (after the permitted number of retakes) cannot proceed to the membership and are therefore effectively barred from a full career in psychiatry. It is unsatisfactory that the entry to further training is decided by the result of an examination in basic science alone; there is a strong argument for a test of clinical aptitudes as well as, or instead of, the test of knowledge of basic science. If a clinical examination is made part of the preliminary test, it would be most appropriately concerned with interviewing skills, including the ability to elicit clinical phenomena and assign them to syndromes. In other words, the assessment of preliminary clinical ability should be mainly concerned with diagnosis, rather than with details of aetiology, treatment and prognosis all of which may require a wider knowledge than can be reasonably expected from a trainee at the end of his first year.

If the preliminary test is to include a clinical examination of this kind, it would be appropriate for the written part of this initial test to assess clinical topics as well. At present the preliminary test includes questions on dynamic psychopathology. In future it might also include descriptive psychopathology.

If these additions are made to the preliminary test, some topics must be removed to make way for them. It is logical to choose the topics to be removed by considering first which topics have the greatest reason to remain. Neuroanatomy is one, since some knowledge of this subject is essential for accurate neurological examination, and this skill could usefully be tested along with the ability to make a psychiatric assessment. Principles of therapeutics (for example, reasons for drug interactions) might also be examined at this stage because the trainee needs this knowledge early in his training. Some psychology might be examined (for example, psychometric principles and some neuropsychology) but certain topics might be reserved for a later stage—for example, developmental psychology might be learnt with child psychiatry and examined in the membership examination.

Basic sciences and the membership examination

The foregoing comments lead naturally to a consideration of the basic science component of the membership examination. At present this content is not substantial, and too many candidates close their minds to basic science after they pass the preliminary test.

There is a strong argument for including a larger element of basic science in the membership examination. This could be examined with questions requiring a knowledge of both basic science and clinical

psychiatry—for example, a question enquiring about the biochemical processes leading to the formation and breakdown of monoamines in the central nervous system, and the theories which have implicated these substances in the aetiology of affective disorders. Such an approach to examining would go some way to testing the important ability to relate scientific and clinical knowledge to one another.

Methods for examining clinical skills

In an ideal situation, the examiner might observe the candidate interviewing more than one patient, and applying the clinical interview for more than one purpose (namely, for diagnostic, therapeutic, and explanatory purposes). However, public examinations have to be practicable (that is, convenient to administer), as well as valid and reliable; they are constrained by considerations of time, cost, the willingness of patients to take part, and the capability of examiners to leave their day-to-day work. These considerations make it unlikely that the clinical examination could involve many more patients than are called upon at present, or that the examiners could spend much more time with the candidate than they spend now. Nevertheless, it should be possible for an examiner to watch the candidate during some part of his interview with the patient. For example, the candidate might be required by the examiner to demonstrate the salient features of the mental state.

Another method of examining the candidate's clinical work used in some countries is the case book, a series of written accounts of the history, examination and treatment of individual patients. This method of assessment has been commended as particularly useful in assessing candidates' psychotherapeutic work. If each case study includes a brief literature review, it can also test the ability to relate academic to clinical knowledge. The disadvantages of case books are that they are difficult to mark reliably (and time-consuming for the examiner), and that the question can arise occasionally whether they consist solely of a candidate's unaided work. Because of these difficulties it can be argued that although the writing of case books is a good form of training, the assessment of case books is not a valid and reliable form of examining.

The membership examination is a general examination taken by trainees who will eventually practice one of the sub-specialties as well as those whose practice will be in general psychiatry. In principle, it should call for clinical assessments of children, young people, the mentally handicapped, and offenders. In practice, it is very difficult to enlist suitable patients for the examination, and the clinical test is likely to continue to be mainly a test of general psychiatric skills.

Information for candidates who fail

Failure in an examination should not only be a set-back. It should also be an opportunity for the candidate to identify the gaps in his knowledge and the inadequacies in his clinical skills. When there are only a few candidates, it is easy to arrange a discussion, soon after the examination, between the examiners and each of the failed candidates. In a large examination, with many examiners and many candidates, this desirable arrangement is difficult to implement.

The final decision about success or failure is reached in a meeting of an examinations committee, most members of which may have taken no part in examining individual candidates. Because of this, advisers who have not been the actual examiner will find it much less easy to transmit useful information to candidates. Nevertheless, if they have available detailed reports by examiners about candidates, advisers can transmit some useful, potentially remedial, advice to candidates who fail, or to their tutors, or to both. This is important at both the preliminary test and the membership examination, but it is arguably more important after the preliminary test, because repeated failure at this stage may be an indication for redirection of the candidate's career (for example, advice to move to another specialty because of a lack of aptitude for psychiatry), or otherwise guidance about ways of improving the candidate's knowledge and technical skills.

Training for examiners

There are general skills of examining which are not possessed by every new examiner when he begins his work. There are also conventions about the conduct of a particular examination which have to be learnt, for example the amount of time to be devoted to any special clinical interest of the candidate as opposed to his knowledge of general aspects of psychiatry. Both these matters are reasons for induction courses for new examiners in which rules can be conveyed and learnt, and techniques improved by watching experienced examiners at work and by examining in the presence of a more experienced observer.

Examiners also need training if they are to mark papers consistently and reach reasonable agreement about their marks. These problems can be reduced by taking care in setting unambiguous questions and by providing clear model answers and/or criteria for marking. However, the problems also point to the need for new examiners to mark specimen papers before they start their real work, and for discussion between examiners of the causes of any gross discrepancies in their independent marking of individual papers. Such training is expensive, and the cost has to be borne by candidates' fees. A balance

has to be struck between inadequate preparation of examiners and an over-zealous form of preparation.

The timing of the examination

At present, the membership examination is taken after three years of approved training. The view is often expressed that although this is a desirable period of preparation for the average candidates, it is unduly restrictive for exceptional trainees—it restricts the 'high-flyers'. Another powerful argument can be added to the preceding ones: the three years required training are a serious obstacle to training in research (see also Chapter 12).

In practice, the requirements for entry to the membership examination are less restrictive than they at first appear. This is because two kinds of allowance are made for experience outside clinical psychiatry: up to a year can be claimed for recognised training in general medicine or in research relevant to psychiatry. In practice, many of the 'high-flyers' can claim exemption for one or other of these reasons and can take the examination after two and a half years of clinical psychiatry.

It has been argued that, as it becomes increasingly favoured by entrants to psychiatry to move directly from pre-registration house appointments to a specialty training scheme, there is an increasing number of trainees of exceptional ability who do not qualify to take the examination earlier by benefiting from either of the above dispensations. Such people, it is argued, should be able to take the examination after two years of clinical training, thus enabling them to undertake research in the third year without the distracting prospect of a professional examination ahead. Against this view, it is pointed out that this year of research can nearly always be counted towards the training requirements for the membership (the exception is basic research without clinical relevance, and it is unlikely that the candidate would be engaged in this). Therefore all candidates would gain by taking the membership after two years, instead of the required three; during the third year there would be the absence of the distraction of an examination ahead. It can be argued that, for the 'high-flyer', this is a small disincentive to research, and that there are different reasons for the poor commitment to research among psychiatric registrars.

EMPHASES

8.1 Failure in the preliminary test eliminates candidates, and the test therefore should assess attributes needed for a career in psychiatry as well as the relevant basic sciences.

8.2 Improvements and innovations are needed in methods for examining clinical skills of candidates.

8.3 Candidates who fail require responsible and effective advice and guidance.

8.4 Training of examiners is a crucially important aspect of the examination.

8.5 The timing of the membership examination, and its place in professional development, is under scrutiny.

9 Training settings

The traditional setting in which psychiatrists-in-training learn their professional skills is the psychiatric hospital. Other important settings, given increasing emphasis, are: 1. the general hospital, and 2. the community.

1 Psychiatry in the general hospital

Experience in this setting is particularly important to the future psychiatrist because he can gain exposure to liaison psychiatry, which is one of the most crucial areas of psychiatric practice to which trainees must be exposed. It is important for several reasons:

a. The types of patients seen in consultation differ from those seen elsewhere. There is very considerable psychiatric morbidity in patients in general hospitals, who are often both psychiatrically and medically ill; their psychiatric conditions as well as their physical illness may be eminently treatable. Although cases of attempted suicide, most often from drug overdose, form a large part of the routine work, liaison psychiatry encompasses far more than this, and should be a facility for those patients whose medical illness is accompanied by psychological disorder.

b. In the interface with physicians and surgeons, the psychiatrist has demands made on him and responsibilities which are very different from those presenting in a psychiatric hospital. The relationship established between psychiatrist and physician may vary from service to service, and depend very much on the personalities of each. A special challenge to the psychiatrist is that much of the clinical work he undertakes is for patients not primarily his own but chiefly the charge of the physician or surgeon.

c. The regular presence of a competent psychiatrist in a teaching hospital, active in liaison work, can contribute considerably to showing other medical staff what psychiatry implies, and thus may lead to recruiting psychiatrists, not only at the undergraduate level but also at the later stages when senior house officers and registrars in medicine and surgery may be considering whether a career other than in these mainstream specialties may suit them.

2 Psychiatry in the community

Trainee psychiatrists gaining experience in the community have an opportunity to be involved with general practice, and also with the numerous other agencies concerned with mental health and mental illness in the broader sense. The trainee psychiatrist is thereby helped to assess his role in a multidisciplinary context, and to evaluate the various contributions of voluntary and statutory organisations, and the advantages and requirements of working in a team setting. They are given opportunities to attend prisons, courts, and have contact with probation officers. A particular aspect of community work is the opportunity to make substantial contact with family members as well as with the patient. This also enables psychiatrists-in-training to comprehend the special skills of psychologists, social workers, marriage guidance therapists and community nurses. The multidisciplinary approach is of the greatest importance in contemporary psychiatry, and if the trainee is to understand his potential role in appropriate circumstances as the leader, this calls for an intimate knowledge of other members' special skills. Psychogeriatrics provides the special experience of consultation with other disciplines, such as social services and housing services, in arranging the appropriate placement of the elderly. Imaginative innovative part-time placements of psychiatrists-in-training in community organisations are to be welcomed—for example, regular visits to large group general practices as an alternative to conducting conventional clinics in hospital outpatient departments. If, as usually happens, such community assignments include work in crisis intervention teams, then the trainee will learn, as he cannot in any other way, the value of more or less immediate intervention in family dilemmas or emergencies, perhaps permitting an intervention which may make hospital admission unnecessary. As should always occur in hospital-based work, there must be close consultant supervision available for the trainee in all the community activities indicated. Good comprehensive services in the two settings (the community and the general hospital) are by no means easily available at some otherwise well-grounded psychiatric training centres, so acquiring experience in these fields may be limited by considerations of time and travelling distances. It is a responsibility of the hospital clinical tutor to satisfy himself that trainees can receive adequate attachments under appropriate supervision at well-run clinical services. No hard-and-fast rules can be laid down, but the relevant specialist sections of the College should be required to formulate advice which should as far as possible be followed.

3 The psychiatric hospital

The psychiatric hospital is taken to include both acute admission wards and those for the longer-stay groups of patients, particularly psychogeriatric patients. Such hospitals are sometimes viewed in certain quarters, as a consequence of *A Hospital Plan for England and Wales* (GB, MoH, NHS, 1962), as outmoded, but they will continue for the foreseeable future to be an integral part of the psychiatric services as a whole, incorporating a considerable quantity of manpower, money and time, not only, of course, of psychiatrists but also of nurses and other colleagues. The character of wards in such hospitals should range from the therapeutic community orientation which is particularly useful for the handling of acute disorders, to the more 'medical' structure of those wards dealing with more chronic psychiatric disorders and with the many patients who are physically as well as mentally infirm. The dangers to be counteracted in large mental hospitals are those of any big institution: loss of individuality, being too impersonal, inflexibility and general inertia. Previous practice may have led to a considerable silting up of chronic patients, a disadvantage which can be stultifying unless consultants show special initiative to reduce institutionalisation. A further disadvantage is the remoteness from the community which can be a serious limitation.

The goals of experience in the psychiatric hospital are to provide an appropriate range of experience especially in those difficult areas of chronic fluctuating conditions seen in schizophrenia and in the elderly. Also provided are special facilities for the chronically disabled and the chance to institute a fairly broad range of rehabilitating programmes, and also special units for mentally ill offenders. District general hospital units are unfavourable for chronic patients, and may cope less well with any high degree of disturbance in psychiatric patients who are often better managed in the larger psychiatric hospitals. Psychogeriatric services are often advantageously placed in a large psychiatric hospital which can provide a well organised range of services, and thus afford greater clinical experience than a small assessment unit in a DGH, for example.

The large number of staff working in a mental hospital can also provide special advantages. A variety of consultants may be found on the staff, and often a number of social workers and psychologists. If all these colleagues are active in vital clinical units, a range of individuals with special interests and expertise can add to the trainee's experience. A large institution also provides administrative experience, in the hospital context. Junior doctors have chances to meet nursing and general administrators regularly, thus obtaining

experience of negotiation and the attempts that must be made to solve problems in committee. It is important that the psychogeriatric wards should have a very close liaison with the general geriatric services, with regular interchange of patients and staff, including trainees.

4 Child and adolescent psychiatry and the other specialties

Community psychiatry corresponds in certain ways to aspects of child and family psychiatry, though to be comprehensive the latter should also have its own liaison work with paediatricians. For historical reasons, but still true at the present time, child and family psychiatry has often been the area in which psychiatric trainees are most exposed to family interactions and processes as opposed to the descriptive psychiatry or the quasi-medical approaches in general adult psychiatry. Some trainees may have considerable problems in reorientating themselves for the different nature of the experience, and clinical tutors have a special responsibility in this regard. The contact between trainee and particular patients and families should optimally be as long as possible (six months is hardly adequate, even if the possibility is given to the trainee of continuing to see a few cases after the formal assignment is over). Although trainees should have the opportunity to visit various community organisations (such as children's homes, juvenile courts, day centres), their main base must be a general child psychiatry clinic where they should see the full range of available treatments. If the clinic is on education authority premises, then special efforts must be made for the trainee to work for regular sessions in hospital settings, such as paediatric wards and outpatients; if, on the contrary, the clinic is hospital-based, then some experience of the education authority's services must be obtained so that the whole range of community provision is seen. Many of the problems referred to a child psychiatrist are situation-specific, for example, misbehaviour at school, and an assessment of relationships and attitudes of significant members of that community, in conjunction with the educational psychologist, is called for in order to arrive at correct diagnosis and treatment. Special arrangements may have to be made for trainees to see adolescents who are often referred to psychiatrists by general physicians in the larger hospital settings, and through voluntary agencies in the community.

Among the other sub-specialties in psychiatry, mental handicap and psychogeriatrics need special mention as important settings for training, though the main point to be made about both is the same as for child psychiatry; that is, the community services are at least as important as the hospital-based components in the care of these patients.

5 Allocation of time

The allocation of time between the different settings necessary for psychiatric training is difficult to determine. Simple sequences of short full-time blocks are not satisfactory as they do not provide the continuity of doctor-patient relationship which is essential if psychiatric illness and its management in so many settings is to be understood. Under certain conditions, child psychiatry and community psychiatry might run concurrently for a nine- to twelve-month period. Similar periods are in order for a psychiatric hospital-based service which deals with acute inpatient units and psychogeriatrics. If a mentally handicapped unit is at hand, residential experience can be provided, though some understanding of a community contribution to subnormality should take place in the child psychiatry and community settings. Psychotherapy, in the broadest sense, should be taught concurrently throughout the whole period of training by seminars and proper supervision of trainees, who ought to be treating a few patients both individually and in group therapy for as long a period as possible (extending over years rather than months). In addition, trainees should become familiar with short-term treatments and with behaviour modification, preferably by participating in the actual management of one or some of their own patients. There are great advantages in multidisciplinary supervision of these clinical methods, and use should be made of non-medical therapists if they have the necessary experience, authority, and teaching abilities. Such a range of treatment experience may be difficult to obtain in some hospitals.

The other sub-specialties, such as forensic psychiatry, alcohol problems and drug addiction, could be properly dealt with at the registrar stage by relatively short-term full-time secondments (two to four weeks) or combined for longer periods part-time with general psychiatry training, together with systematic lectures and seminars.

6 Rotational schemes

There is a major geographical constraint applying to the use of hospitals, clinics and community services for teaching. Ideally, all these should be in association with a university department of psychiatry and the related hospitals. For training purposes (especially in psychotherapy) trainees need to see certain patients regularly (weekly or more often) over a long period of time (at least one year). This is clearly impossible if journeys between hospitals or clinics of more than a few miles, or lasting more than half an hour, are necessary to achieve the required and varied experience. Likewise, regular university teaching sessions must be available, and as these can often be economically organised for quite large groups (10–20

trainees) it follows that a few large university-based training schemes are much preferable to smaller groups which are widely scattered. Training schemes that involve the trainees in rotating through two or more hospitals must be primarily to provide a wider and more comprehensive range of clinical settings than the trainee can find in any one hospital. Undue movement of trainees should emphatically *not* be used to meet service needs of hospitals that would otherwise be inadequately staffed (other ways must be found to deal with unmet service requirements). Some trainees have a do-it-yourself rotational experience by moving from one job to another by availing themselves of the ordinary appointment committee system. This has the disadvantage of lack of continuity of supervision of training by a single clinical tutor who has an overview of the trainee's experience and the undesirable gaps which may occur. Rotational schemes are understandably unpopular with trainees if the hospitals involved are so far apart that a move of house is necessary. Such schemes are particularly inconvenient for part-time trainees with domestic commitments. There has to be some 'parity of esteem' between hospitals involved in rotational schemes, otherwise trainees will simply move to another job when their turn comes to work in what they (and perhaps some of their teachers) perceive as an inferior institution.

The observations expressed about rotational schemes apply equally to senior registrars as to trainees in basic specialist training, but some further comments are needed on senior registrar training settings. The relatively small number of senior registrars who wish to go full time into specialties such as child and adolescent, forensic or old age psychiatry, or psychotherapy, must be prepared to work in one of the 'centres of excellence' in these specialties and accept the places and conditions of work available there. There are more difficulties for the majority, those who wish to remain in general adult work, perhaps with a 'special interest' in one of the above or in other specialties such as alcohol problems, drug dependence, rehabilitation, and so on. Some of the existing rotational schemes between university centres and other hospitals (a better terminology than teaching and non-teaching which begs the question) are too inflexible and too dependent on service commitments. The idea that senior registrars are supernumerary to service establishments has had little reality in psychiatry (save perhaps in Scotland). The rotating schemes were for the most part designed before the rise of many of the specialties and before the majority of senior registrars had family commitments which make moves of house difficult. Senior registrars' training requirements for general psychiatry, and for the newer specialties mentioned above, need a wider consideration than simply an analysis of training settings. Hospitals and their associated com-

munity services in which higher training is provided should be chosen as 'centres of excellence', whatever their location and size, provided that a close relation to university departments is maintained.

7 Undergraduate teaching

For medical student undergraduate teaching, the essential component is an adequate university department of psychiatry housed in the main teaching hospital, and seen therefore to be an integral part of medicine. There is no substitute for such a base, from which experience of all other aspects of psychiatry not available there can, if necessary, be planned. As far as community and crisis intervention work is concerned, careful supervision is needed. Valuable though such experiences may be to psychiatric trainees, the exposure of undergraduates to these can be unsettling unless adequate supervision is responsibly provided, because to some it runs directly counter to the one-to-one doctor-patient orientation practised in almost all other branches of medicine. For this reason some medical students may reject this experience, sometimes expressing some such objection as 'they did not enter medicine to do social work'.

8 Hospitals without trainees

A number of factors will operate in the future—and indeed some are already occurring—which will concentrate trainee psychiatrists in fewer centres and thus result in a situation where some consultants, especially those in geographically isolated psychiatric hospitals or small DGH units, will no longer work with trainees. One development will be a reduction in the number of trainees, in line with the implementation of the Short report (GB, Parliament, House of Commons, 1981) (although not as great as was originally anticipated). Other developments will be the raising of training standards, greater educational expectations from trainees, the demand (particularly by overseas doctors) for more time in teaching hospitals, and the need for a certain 'critical mass' of fellow-trainees with whom to be in regular association. There are other factors, on the other hand, which will retard this centralising tendency. The Short report emphasised the value of including peripheral hospitals as part of well-organised rotational training schemes, recognising the fact that valuable experience and experienced teachers exist in them. Another factor is the very real anxiety that removing trainees from a hospital will cause a fall in the morale and enthusiasm of consultants, so that some will seek to move to centres retaining trainees; the consequence will be that it will become increasingly difficult to attract new consultants to fill the vacated posts, with a resulting decline in consultant numbers.

In these circumstances how can the morale and intellectual activity of the consultants in hospitals without trainees be maintained? The Royal College is currently considering this problem. Some possible solutions to this dilemma might include the following:

a. There are efficient and active units, for example the Seymour Clinic at Swindon, which have given up trainees, and where the supporting staff are part-time practitioners. More hospitals might seek to imitate this development.

b. The establishment of more research units in psychiatric hospitals by the Department of Health and Social Security and the Medical Research Council, such as has taken place in the past at St John's, Graylingwell, Runwell and Whitchurch, would act as a powerful boost to morale.

c. Psychiatric trainees are not the only people who need education. Consultants could increase their training commitments to groups such as general practitioners, nurses and social workers. Many medical students, moreover, go to peripheral hospitals for a number of weeks as an elective period, a practice which can be fostered.

d. In the future continuing education for consultants will be a major factor in maintaining standards and morale. A number of consultants have retrained themselves in mid-career—often with the help of the British Postgraduate Medical Federation—and some have moved to work in teaching hospitals. This retraining should continue to be augmented. Continuing education, including sabbatical leave as a right, should be more available for consultants. Indeed, the major problem may be not one of providing appropriate courses and the financial provision for it, but that of persuading consultants (often those most in need of intellectual stimulus), to avail themselves of continuing education opportunities. The development of provision for continuing education is a foremost immediate responsibility of the Royal College.

EMPHASES

Training settings must include:

a. a general hospital psychiatric liaison service;

b. community psychiatry with special attention to multidisciplinary work covering the whole age range from child psychiatry to psychogeriatrics; and

c. a general psychiatric hospital (or hospitals) providing all types of inpatient units.

The selection of hospitals and community settings for training posts must depend not on the service needs of the institutions or agencies, but on their suitability for training by reason of the quality of the consultant staff, their teaching capacity, and the ready availability of the resources of a university department of psychiatry. Though psychiatrists-in-training may need to rotate through several different clinical services scattered over more than one site to gain adequate breadth of experience, it is important that this does not impede them from having the opportunity of long-term contact, of at least a year's duration, and under regular supervision, with some patients, families and groups in order to gain experience of such clinical modalities as the psychotherapies. Consideration of continuing education facilities must be given to consultants in hospitals who will in the future be left without trainees because of increasing concentration of training in fewer educational settings.

10 Liaison psychiatry

Definition of liaison psychiatry

Liaison psychiatry is defined as those clinical, teaching and research activities of psychiatrists carried out in a non-psychiatric department of a general hospital (Lipowski, 1971).

A distinction has been made between consultation and liaison (Lipowski, 1974). Consultation takes place when the psychiatrist has a patient referred to him and an opinion is given on that patient alone. Liaison has been used to refer to those activities of a psychiatrist when he is attached to a particular department and offers continued support for patients, and sometimes also for staff. A rigid distinction between the two terms is not helpful and it is now widely recognised that good liaison is essential to the performance of the basic work of consultation (Lipowski, 1981).

Liaison is clearly an important function of all psychiatric work, whether it involves psychologists or social workers, whether it takes place in hospital or with general practitioners or others outside the hospital. It may be misleading in some contexts to confine the use of the term 'liaison psychiatry' to the definition given above.

Liaison psychiatry in North America

Although a relatively new field in the United Kingdom, liaison psychiatry has been established in North America for some years. Its historical development has been reviewed (Lipowski, 1974) and its emergence in the 1930s coincided with the interest at that time in psychosomatic medicine. There followed a decline in interest during the 1950s and 1960s with the disillusionment with psychosomatic theories then current. A resurgence of liaison work has occurred since the beginning of the 1970s partly due to a major increase in funding that was made available particularly for psychiatric education for doctors in general medical specialties, especially general (family) practice. Now nearly all general hospitals in America have liaison units, and training posts in such units are part of most psychiatric residency programmes (Lipowski, 1979).

Actual practice varies from unit to unit, depending on the number of staff. There does, however, appear to be a recent tendency to move away from the intensive liaison attachment to general hospital departments that was advocated a few years ago. Now stress is placed on

the need to offer efficient consultation services. Units give more emphasis to the value of teaching, and it appears that liaison teaching is valued by medical students (McKegney and Weiner, 1976), and psychiatric residents (Lipowski, 1974), and by non-psychiatric junior medical staff (Brown and Jacobsen, 1976). As yet there has been no proper evaluation of liaison psychiatry in respect of either its clinical effectiveness (Lloyd, 1980) or its training effectiveness (Cohen-Cole, 1980).

There seems to be fairly widespread agreement by North American liaison psychiatrists that they improve the image of psychiatry in the eyes of their medical colleagues. However, there has been no objective evaluation of its ability to influence the attitudes of students towards psychiatry, and its influence on recruitment to psychiatry is not known.

During the period that liaison psychiatry has expanded there has been a fall of 60 per cent in the number of North American medical students choosing psychiatry as a career (Neilsen, 1980). It seems likely that more psychologically-minded students during that period were drawn to family medicine. Liaison psychiatry could disappoint students attracted to a form of psychiatry where they perceive that psychosocial theories are given more emphasis.

Many North American centres have hesitations about the term 'liaison psychiatry' because it stresses a linking activity rather than a sub-specialty based on specific skills of its own.

Liaison psychiatry in the United Kingdom

Liaison psychiatry has been much slower to develop in Britain. However, interested psychiatrists have always been active, and surveys made 10–20 years ago showed that between 0.7 and 2.8 per cent of general hospital patients were referred for a psychiatric opinion; many of these were self-poisoning patients (Anstee, 1972). Some studies in the late 1960s described teaching in liaison psychiatry (Crisp, 1968; Macleod and Walton, 1969; Wolff, 1970). It seemed that such teaching was appreciated, but there was little formal evaluation of the effect of liaison psychology on student attitudes to psychiatry and the extent of its influence on career choice.

A study in Scotland (Brooks and Walton, 1981) showed that liaison services and attitudes towards them varied greatly in different regions of the same country, and that separate divisions dealt with as wide variations as between 300 and 1,200 referrals each year. In Leicester a recently developed liaison service saw 400 self-poisoning and 300 other referrals from the general hospital in its first year. This service currently sees about eight self-poisoning and ten other new referrals

each week. These figures indicate the clinical need for a liaison service, however that service may be structured and provided.

Liaison psychiatry teaching for medical students

A recent survey explored the current teaching and training in liaison psychiatry in England and Wales. The 25 teaching hospitals were contacted and 21 (84 per cent) replied. Three (14 per cent) had a specific liaison psychiatrist who devoted a proportion of his time to this field. Two medical schools (10 per cent) had neither a liaison psychiatrist nor a general psychiatrist with an interest in liaison work.

The medical schools were asked how often students saw and were taught on general hospital referrals, and the results are given in Table 2 (opposite).

It would appear if self-poisoning cases are omitted, that about half the medical schools provide almost no practical experience in liaison psychiatry. The survey also showed that lectures or seminars in aspects of liaison work were scanty, only three schools (14 per cent) providing extensive coverage in formal teaching.

It has been suggested that liaison psychiatry could best be taught to medical students during their attachment to general hospital firms by arranging joint sessions with clinicians to discuss psychosocial aspects of that specialty. The number of schools providing such experience is shown in Table 3 (opposite) and again it appears generally uncommon.

The survey also showed that whereas all schools taught medical students how to take histories, only six (29 per cent) provided training in counselling the medically ill. It thus appears that liaison psychiatry is still a relatively neglected subject in most medical schools.

Oxford, Westminster, University College, King's College Hospital, Nottingham and Leicester, seem to provide above-average experience. A study in 1978 showed no increase in medical students choosing psychiatry as a career from these medical schools (Faragher, Parkhouse and Parkhouse, 1980).

Liaison psychiatry experiences for psychiatric trainees

It may be that experience of liaison work in psychiatry is a significant factor in influencing career choice. If it is to influence recruitment for the better, it probably will have to be practised efficiently and therefore taught properly to trainees. A survey has recently been carried out to find out the amount of teaching experience in this country which trainees had in liaison psychiatry: 50 per cent of all psychiatric tutors in England and Wales were questioned and of the 82 training schemes contacted 52 (63 per cent) replied. All 52 schemes had to provide psychiatric cover for at least one general hospital.

Table 2 Number of medical schools providing liaison experience for medical students

	Often	*Occasionally*	*Rarely*	*Never*
Self-poisoning referrals	3 (14%)	10 (48%)	6 (29%)	2 (10%)
Casualty referrals		9 (43%)	6 (29%)	6 (29%)
Other ward referrals		12 (57%)	6 (29%)	3 (14%)

Table 3 Number of medical schools providing liaison teaching on general firms

Often	4 (19%)
Occasionally	4 (19%)
Rarely	7 (33%)
Never	6 (29%)

Table 4 Number of psychiatric training schemes providing liaison experience

	Often	*Occasionally*	*Rarely*	*Never*
Self-poisoning referrals	23 (44%)	25 (48%)	3 (29%)	1 (2%)
Casualty referrals	7 (13%)	28 (54%)	10 (19%)	7 (13%)
Other ward referrals	2 (4%)	26 (50%)	20 (38%)	4 (8%)

Table 5 Medical students' attitudes to psychiatry in relation to adequacy of liaison experience

		Above average liaison psychiatry teaching		
Medical school	*N*	*Before*	*After*	
(1) A	17	97.6	107.3	+ 9.7
B	16	92.8	107.2	+14.4
(2)	14	100.2	109.6	+ 9.4
(3)	11	95.4	115.2	+19.8
		Average liaison psychiatry teaching		
(4)	11	93.8	93.4	− 0.4
(5)	12	99.8	100.8	+ 1.0

Four schemes (8 per cent) had a specific liaison psychiatrist, and 28 (54 per cent) had a general psychiatrist with an interest in liaison psychiatry. However, in 20 schemes (3 per cent) there was neither. Table 4 (page 105) shows how often trainees had experience of liaison referrals.

The vast majority of psychiatric trainees get at least occasional experience with self-poisoning referrals, but a third get almost no casualty experience and nearly a half have little chance of seeing general ward referrals. Fifteen schemes (29 per cent) had a specific consultation/liaison rotational post for their trainees but the rest (71 per cent) had no such attachment and trainees could only get liaison experience through duty rotas, or the sporadic referrals made to their consultants. In 13 schemes (25 per cent) there were opportunities for trainees to form links with certain general hospital departments (usually geriatrics, general medicine,or neurology). These links usually provided further teaching for the psychiatric trainee rather than specific liaison cover for the medical unit concerned.

These results suggest that, as with medical students, liaison psychiatry is also relatively ignored in the training of junior psychiatrists. A recent survey of different types of experience received by newly appointed consultant psychiatrists does not mention experience of liaison work, and this only serves to underline the neglect of general hospital psychiatry (Brook, 1981).

Liaison teaching and attitudes to psychiatry

From the survey of medical schools it emerged that six schools offered above-average teaching and experience in liaison psychiatry to their students.

A comparison was made of the attitudes towards psychiatry held by medical students from certain of these schools offering above-average experience, with schools offering average experience only. The attitude to psychiatry questionnaire was used, which has 30 statements about various aspects of psychiatry; each statement allows the student to rate his response on a 5-point scale from 'strongly agree' to 'strongly disagree'. This allows a total score to be assessed numerically and therefore a change in attitudes over a period of time to be assessed.

The scores are shown in Table 5 (page 105) of students before and after their psychiatric clerkship in the three schools offering above-average experience (one school supplied results for two separate clerkships) and in two schools offering average experience in liaison psychiatry.

It can be seen from Table 5 that in the schools with above average

experience there is a positive increase in attitudes towards psychiatry from 9.4 to 19.8 points between the beginning and the end of the clerkship, whereas in the two schools with average experience there is no real change in attitudes during this period.

Only tentative conclusions are possible from this small study with small numbers of students. It is possible that the schools which offered more experience in liaison psychiatry also offer more teaching in psychiatry in general and this could explain the differences found. However, it is possible that the more positive attitudes towards psychiatry were due to liaison teaching and experience, which would correspond to the views of both students and teachers in this field who consider that liaison work has much to offer in the psychiatric clerkship. This study needs to be repeated on a larger scale.

Liaison work and attitudes to psychiatry

The high psychiatric morbidity on general hospital wards and the considerable service need to be filled has long been recognised, and will clearly continue (Maguire and others, 1974; Lancet, 1979a). Liaison work, as well as providing a service, could help to educate non-psychiatric doctors in the recognition and management of psychiatric morbidity, and this could lead to better and more appropriate referrals, together with a better recognition of the potential and the limitations of psychiatry.

It may be that liaison work could change some of the negative attitudes towards psychiatry that students develop either during their teaching (Lancet, 1979a) or by modelling on other medical staff with critical and negative attitudes (Mezey and Kellett, 1971; Mason, 1975).

Liaison work brings psychiatrists into regular contact with medical and surgical colleagues in the management of the same patients, and provides the psychiatrist with the opportunity to demonstrate what he may have to offer in their general management, and hence that psychiatry is not a subject unrelated to the rest of medicine. Such liaison work could improve the professional image of psychiatrists by showing that their work is not restricted to mental hospitals. At the same time if liaison work can be seen to be beneficial for the psychiatric disturbance of patients with physical disorders, this may go some way towards removing the common misconception that psychiatric conditions are incurable.

Finally, in relation to attitudes towards psychiatry it is often implied that psychiatrists are relatively inactive and this misconception could again be corrected by energetic liaison work on the part of

a psychiatrist prepared to make himself available for the management of difficulties experienced with general hospital patients.

Liaison work and student teaching experience

To the extent that medical students feel that psychiatric teaching is unrelated to their medical training, teaching in liaison psychiatry could reduce this negative orientation. Formal teaching of liaison principles would best occur during a psychiatric clerkship when it should be possible to devote more time to such aspects as confusion in organic states, psychological reactions to physical illness, dying, psychogenic illnesses, and attempted suicide.

Practical experience could come from involving students in liaison referrals which offer very good teaching opportunities. The student could benefit greatly from being the first to assess a patient, then having the opportunity to discuss the presenting problem with an experienced psychiatrist. The relevance and impact of such teaching would be greatly increased if a clinician from the referring department was also involved. Such sessions would confirm for students that psychiatric teaching is relevant to the rest of their medical training. Liaison teaching could also be provided for students during their clinical attachments by having a psychiatrist attend ward rounds or teaching sessions on general wards. This psychiatrist could provide teaching and advice on the management of patients with psychiatric problems, and might also be in a position to indicate the relevance of psychological factors in illnesses, in cases where these have not been previously recognised.

Dangers of a two-tier service

It has been suggested that new posts should be created for psychiatrists with a special interest in liaison work. Designation of such special interest and provision of a general hospital base might well lead to an increase in status of such consultants in the eyes of medical and surgical colleagues. Quite apart from shortage of psychiatric manpower not permitting this development, however, there might be a danger that such liaison workers would become split from the mainstream of general psychiatry and be without general psychiatric responsibilities. Such psychiatrists may become isolated from their colleagues, and while on this account they may be seen by some medical staff as more acceptable, there is a danger that psychiatric work in the wider context (in such areas as psychogeriatrics, mental handicap, and long-term psychotic illness, for example) may fail to gain the recognition required.

Psychiatry and the general hospital

Leaving aside the large number of people admitted to hospital following attempted suicide, which forms the bulk of the psychiatry practised in some general hospitals, abundant evidence exists of the substantial psychiatric morbidity always present in general hospital wards. Clearly a service needs to be provided but the questions remain: who is best equipped to provide the necessary service, and how is such a service best provided?

There are advantages in having all psychiatrists maintain contact with general hospitals where this is geographically possible. There is little doubt that the reputation of departments of psychiatry very often depends on the quality of their liaison work. Psychiatrists could benefit from continuing medical education within general hospitals; indeed, some would argue that it is impossible to do liaison work effectively without a more extensive training in general medicine and a very regular contact with general medical and surgical wards.

Liaison work is easy to do badly and where all psychiatrists take part, a patchy and inconsistent service may be provided. This can do little to help the image of the profession as a whole, or to aid recruitment.

In many areas, patients who have taken overdoses are routinely referred for psychiatric opinion. Recent reports have been directed at helping junior medical staff and social workers to assess such patients, and their need for psychiatric referral (Gardner and others, 1982). The number of such patients would almost certainly overburden any liaison service, but the continuing education of medical and paramedical colleagues may in the long run help to relieve what has come to be seen by many as a burdensome duty.

Liaison work and psychotherapy

Having emphasised that those in liaison work need a more than basic education in general medicine, it has also to be emphasised that they need to be more than adequate psychotherapists.

Competent liaison work involves an awareness of and a sensitivity to the defence mechanisms used by both staff and patients on general wards. There is much need for basic counselling and support, as well as the ability to teach these skills to others. Areas of chronic illness and transplant surgery present their own particular problems. Very primitive defence mechanisms may be involved as a person recognises his dependence upon regular medication, a walking frame or a dialysis machine, and recognition of such dependence should lead to far greater emphasis on psychotherapy. Increasingly sophisticated medical technology is likely to produce more specific emotional

disorders which may require further specialised clinical experience and skills in psychiatry.

The ideal liaison service

The prime aim of liaison work is to provide a service and all teaching and research are primarily a means to this end.

The psychiatrist's service role in the general hospital should be seen in terms of treating recognised psychiatric morbidity, discovering undetected psychiatric morbidity, and the prevention of psychiatric morbidity. Ideally much of this would be done through the education of medical and nursing staff. Another aspect of liaison work could be seen as helping the staff cope with their own conflicts and stresses, which may be greater on certain wards, such as those treating a large number of terminally-ill patients.

Liaison psychiatrists should have an important role in educating doctors, medical students, nurses and other paramedical staff. It is unrealistic to think that a psychiatrist could screen all patients passing through a general ward; however, nurses who are motivated enough could easily be trained to recognise changes in personality, or mood, which might suggest the onset or presence of psychiatric disorder. An interest in and good understanding of the psychodynamic factors at work in general wards would be essential, and group work may be possible in some situations for staff or patients.

Research is essential in evaluating the service being provided for patients in terms of reduced morbidity, and for staff to evaluate changed attitudes. Research would clearly be time-consuming as would any form of good liaison work, and would require the regular and consistent attachment of a psychiatrist to one unit or ward over a long period of time.

One of the common criticisms of a liaison service is that it greatly increases referrals. There may indeed be a stage in the development of the relationship between a psychiatric service and a particular unit when referrals increase. This need only be a temporary phase as medical colleagues may come to find that they can handle minor psychiatric disorder themselves, as the liaison psychiatrists find more appropriate referrals coming their way where more intensive work is possible.

The future of liaison work

Limitations of manpower and organisational problems make it unlikely that the ideal will ever be attained. At present there can be few places in this country where adequate service is given for the psy-

chiatric needs which are recognised on general wards. The ambitious aim of preventive psychiatry in general hospitals is scarcely feasible in more than a limited way at the present time. There is a danger that the increasing technological sophistication of modern medicine will lead to an increasing preoccupation with organic illnesses and disabilities, with the consequent neglect of any accompanying increase in emotional distress.

Liaison work will have to continue, under whatever name. In the future there may be a more important role for physicians with a special interest in psychiatry or in the emotional aspects of physical illness, as well as psychiatrists with a special interest in liaison psychiatry.

EMPHASES

10.1 There is a large and increasing service need for liaison work in general hospitals to treat, recognise, and prevent psychiatric morbidity.

10.2 Manpower and organisational constraints may prevent ideal liaison services being set up in the near future, but should not prevent the criteria from being defined.

10.3 Evidence has been presented to show that teaching in medical schools and to trainee psychiatrists in liaison psychiatry is far from adequate in the United Kingdom. Liaison psychiatry has the potential to alter the negative attitudes towards psychiatry found in general hospitals, and there is some suggestive evidence that medical student attitudes become more positive after exposure to liaison psychiatry teaching.

10.4 The reputation of psychiatrists in an area is almost certainly reflected in the quality of their liaison work in the general hospital.

10.5 Fears of a split in psychiatry have been expressed, with the development of a two-tier system if liaison psychiatry becomes a recognised sub-specialty. Such fears may be groundless and more psychiatrists are needed in liaison work.

10.6 Good liaison work requires a strong background in general medicine, combined with a working experience of psychodynamic principles. If such work is to be done well it is likely to require considerable commitment in terms of time taken up in treatment, teaching and research. A good liaison service is likely to have a

marked influence on the image of psychiatry as a whole, and on recruitment to the profession.

Note: Surveys reported in this chapter were carried out by Dr Chris Thomas, Westcotes Hospital, Leicester.

11 Higher training

Higher training follows general professional training. In psychiatry it is the phase of postgraduate professional training undertaken after passing the membership examination of the Royal College of Psychiatrists. Higher training, which usually lasts for three to four years, prepares the trainee for the responsibilities of a consultant post—or for work as an independent specialist in private practice. (The period corresponds, more or less, to that of 'senior resident' in the North American system.)

In the United Kingdom, higher training in all specialties is regulated by the joint committees for higher training. The Joint Committee on Higher Psychiatric Training (JCHPT) has two parent bodies; the Royal College of Psychiatrists and the Association of University Teachers of Psychiatry. In Eire, the corresponding responsibilities are vested in the National Health Board, but in order to maintain standards equal to those in the United Kingdom, inspections are carried out by the JCHPT which reports its findings to the Health Board. The JCHPT was set up 1973, later than corresponding joint committees of other specialties; Sir Martin Roth was the first chairman and Professor Henry Walton the secretary. In the first decade of its life, the committee succeeded in encouraging a substantial improvement in the standards of higher training throughout the country. In its first few years, its visiting teams surveyed all higher training posts in the National Health Service. Many recommendations for change were made and these were for the most part acted on with vigour by the senior psychiatrists responsible for training and by the health authorities. At the same time, the development of the office of postgraduate dean in each health region gave additional strength to the efforts to improve standards of postgraduate education in all the specialties. The growth of postgraduate training and its organisation has been the main development in medical education during the past decade.

At first, efforts to improve higher training in psychiatry met with special difficulties not encountered to the same extent in other specialties. Many psychiatric hospitals are remote from main teaching centres, and from district general hospitals with their postgraduate centres. For these and other reasons, psychiatric hospitals at first had difficulty in mounting programmes of acceptable standards. The JCHPT was able to strike a balance between recognition of these

problems and a rapid action to bring about change. Many hospitals were at first given only provisional approval for training—an interim measure which provides the trainers the time to bring about reasonable and practical reforms. The reports of the teams of inspection of the JCHPT were generally accepted as authoritative and fair, and health authorities and regional organisations for postgraduate training generally accepted the recommendations for action. By the second round of inspections, substantial improvements were noted and standards of training were, with few exceptions, satisfactory. In its third round, the committee concentrated its efforts on encouraging further progress to the extent that no unsatisfactory training posts remain, and satisfactory posts and schemes receive help to raise their standards further.

A review of previous policies on higher training

Now that a firm base for higher training has been established, it is appropriate to look critically at the work of the JCHPT. It is inevitable that such a large educational exercise, undertaken with limited resources and mounted speedily, should have some shortcomings, as well as undoubted achievements. This review will be conducted under the following headings: priorities, location of training, supervision and evaluation.

Priorities in higher training

Inevitably, the first concerns of the JCHPT were predominantly with the form of training. It was important to ensure that higher trainees moved between posts in order to obtain experience with more than one consultant, and to widen their understanding of psychiatry by caring for patients with a wide variety of clinical problems. These aims are essential ones, but it is also important to ensure that a requirement for rotation between posts does not detract from an equally vital aspect of higher training: the ability to take responsibility for the long-term management of patients and for the work of other members of the treatment team. The JCHPT recommends a period of not more than 18 months in any one post in a rotation, this being a reasonable compromise between these opposing aims. Nevertheless, there is a need to interpret rules in a flexible way so as to make room for trainees of exceptional talent and unusual interests. In devising training programmes it is all too easy to allow the good (training for the average doctor) to become the enemy of the best (training for the exceptional doctor).

One difficult judgment to be made concerns the priority to be given to research. Up to one year of full-time research is counted towards

higher training, and all trainees are expected to be able to spend one day a week undertaking research or a special academic study (for example an extensive review of the literature). Although it can be argued that more time should be devoted to research, the undoubted difficulties in encouraging research among trainees seem to relate more to a lack of example from their consultants and to problems in obtaining advice and supervision.

There are even greater difficulties in deciding the priority to be given to training for general psychiatrists in special aspects of psychiatry, such as psychogeriatrics, psychotherapy, drug dependency and rehabilitation. While training in these fields is essential, a rotation which included every one would fragment the trainees' experience too much. In any case, it is not necessary to obtain all this experience at this stage of higher training; and an increasing number of trainees now pass through a comprehensive series of six months' placements in the first three years leading up to the membership examination, prior to higher training.

Finally, there are differences of opinion about the priority to be given to training in administration. It is generally agreed that senior registrars should take part in the committee work of the hospitals in which they hold posts. Some also favour attendance at short courses on administration.

Similar considerations apply to training for the sub-specialties of child psychiatry, psychotherapy, mental handicap and forensic psychiatry.

Location of higher training

Increasingly, higher training posts are organised in rotational schemes which ensure that the trainee spends part of his time in a university hospital and part in a hospital or hospitals away from the teaching centre. Also they usually include some training in general hospital units and some in specialist psychiatric hospitals. It is important that the trainee should gain experience in the different style and organisation of work in these separate kinds of hospital, just as he needs experience of caring for different kinds of patient, and providing different kinds of treatment. This rotation has the added advantage that it usually improves the quality of applicants for posts in the larger specialist psychiatric hospitals.

A further controversial issue has to be faced. Is it desirable to restrict training to a few centres, leaving other hospitals without regular involvement in training? If the needs of higher training are put first, it seems logical to limit training centres in this way. If the efficiency and morale of the consultant staff are put first, then a case can be made for ensuring that all consultants have opportunities for

training their juniors, for teaching is a particularly good way of keeping an informed and critical approach to psychiatry and maintaining the enthusiastic attitudes which make for good patient care. So far, the profession has not reached an agreed answer to this question.

Supervision of higher training

Higher trainees require supervision of two kinds. First the consultant with whom they work should provide a regular time for personal supervision each week, as well as the day-to-day guidance and teaching which he imparts in the course of ward rounds and other clinical activities. Second, the trainee requires guidance from a clinical tutor who should interview him when he enters training and at regular intervals thereafter. These interviews should be concerned both with the trainee's progress and career intentions and with the quality of experience and supervision he is receiving. The clinical tutor should intervene when there are problems in either sphere.

Evaluation of higher training

The JCHPT evaluates training in two main ways. First its visiting teams interview the trainers in order to find out whether the training programme conforms to its requirements as regards type and length of placements, the availability of supervision and advice, the opportunities for private study, and so on. Second, the visiting teams interview those in training in order to find out the quality of the training as they perceive it.

A third kind of evaluation has been made in a series of surveys carried out by Brook (1972; 1974a; 1977; 1981b). In these surveys consultants were asked questions about the training they had received; the more recent surveys refer to training received since the activities of the JCHPT have gained momentum. In the recent surveys, respondents reported improvements in training but these were on a modest scale. No more than half reported satisfactory training in special areas such as psychotherapy, the addictions, mental handicap, and psychogeriatrics. Clearly there is room for further enquiries along these lines, since the newly appointed consultant is able to judge the quality and relevance of his higher training from a better perspective than that of the psychiatrist who is still in training

Training in the sub-specialties

Child and adolescent psychiatry

The recommendations of the JCHPT are detailed and of high quality. The clear statement of the need for at least one long placement is important. As in general psychiatry it is difficult to balance the need for wide experience of different clinical problems and different therapeutic settings, with the equally important need to avoid fragmentation of training.

Mental handicap

The JCHPT is at present reviewing its recommendations in this sub-specialty. This review has had to wait upon a parallel review by the Royal College of Psychiatrists of the role of the consultant in mental handicap (mental deficiency). The College views have now been published; they recognise the need to develop different patterns of work according to local needs but foresee three main patterns. The first pattern is combined posts in child psychiatry and mental handicap of children. The second pattern is combined posts in adult psychiatry and mental handicap affecting adults. These two patterns of work seem likely to increase at the expense of the third which is a sole concentration on mental handicap, with responsibilities for both children and adults. Training for all three kinds of work is being developed at present and the JCHPT is prepared to accept any one of the three provided that it reaches satisfactory standards.

Psychotherapy

The recommendations of the JCHPT emphasise the need for wide experience of different forms of psychological treatment, including behavioural methods. It may be necessary in future to give more consideration to the need to maintain general clinical psychiatric skills among those in higher training in psychotherapy. Also, more attention should be given to research as a part of training, since the development of enquiring, critical attitudes of mind is, of course, as important in this sub-specialty as in others.

Forensic psychiatry

In this area of psychiatry, it is important to avoid over-specialisation in the sense that some aspects of forensic work are, and should continue to be, part of the work of general psychiatrists. For those who enter the sub-specialty, a particular problem concerns the balance of experience between work in prisons, special hospitals,

medium secure units and work in a general psychiatry service. Of these, the first present the most difficulties in finding appropriate arrangements for the supervision of training.

EMPHASES

11.1 The remaining higher training posts identified by the JCHPT as unsatisfactory have to be improved.

11.2 Rotational arrangements should not be at the expense of responsibility for the long-term management of patients and ongoing participation in a clinical team.

11.3 The individual requirements of those in higher training with particular interests or talents should be met.

11.4 The issue whether higher training should be confined only to certain centres needs to be explored further.

12 Training for research

In psychiatry, as in medicine generally, research training is required by three groups of doctors: clinicians, university teachers and full-time research workers. The differing needs of these three groups will be considered in turn. The account is not concerned with the training of the non-medical scientists who work on psychiatric problems in university departments or research units, and their important contributions to advance in knowledge about psychiatry is, of course, not in question.

Research training for clinicians

Good postgraduate training requires that those in training should develop an enquiring and sceptical approach to their clinical work. They should also be able to assess the research work of others, and evaluate scientific advances. These abilities then augment the clinical proficiency of the individual doctor, and when possessed by numerous doctors in a specialty they ensure high standards in the subject as a whole. Black (1981) made the same point when he wrote: 'the greatest enemies of progress in any branch of science are dogmatically held beliefs . . . the best protection from a dogmatic cast of mind is some experience in research'.

Although most psychiatrists would endorse these aims, there is less agreement about the ways in which they can be achieved; also, there are several obstacles to progress. Some of these obstacles concern the trainees, others implicated are in the requirements of the psychiatric training programmes.

Many entrants to psychiatry appear at first to have little interest in the kinds of research that they can undertake most readily in the time available at this stage of their training, namely biochemical or pharmacological studies. Thus many trainees have entered psychiatry because they are concerned with the psychological and social aspects of medicine and any research interests they have are in the same fields. Unfortunately most psychological and social research requires the kind of prolonged enquiry and teamwork that cannot easily be accommodated in the early years of a training programme in psychiatry.

Psychiatric training programmes exacerbate these difficulties. Examinations are usually taken after one year and again after a further two years in order to obtain the membership of the Royal

College of Psychiatrists, which those in training seek to pass as soon as possible. When this qualification has been obtained, only a minority of trainees are willing to step aside from their clinical training to undertake research; the majority proceed to a consultant appointment as quickly as they can, when it becomes difficult to awaken any motivation for research that has remained dormant through the long period of training.

Several provisions are needed to help overcome these difficulties. Without doubt, the most important is the example set by the trainers. Unless his consultant is actively interested in research, the trainee is unlikely to give it a high value. Ideally, the consultant should be engaged in research of his own, or in a collaborative project. If the demands of the trainer's clinical work make this impossible, he should at least demonstrate that he values research, keeps up with advances in knowledge, and encourages appropriate kinds of evaluation of the service he provides. He should also encourage his trainees to adopt an enquiring approach to the problems of their patients, guide them in suitable reading, and nurture any research interests that they show. Without this example, other provisions, however good, are likely to fail. With these points in mind, consideration will now be given to these other provisions.

If the trainee is to do research, he needs to be trained in or near a university. He requires access to a department of psychiatry with an active programme of research, and good links with other research departments. The latter include departments engaged in basic research as well as those engaged in clinical studies. In this way he can receive general supervision from a psychiatrist with research experience and special advice from experts in subjects such as pharmacology and statistics.

The quality of this supervision is important; unfortunately working in an active research centre does not guarantee that the quality will be high. Thus Creed and Murray (1981) found that, at a large postgraduate teaching hospital, only a quarter of the teaching firms encouraged their trainees to undertake research.

Having found a suitable environment and a willing supervisor the trainee needs further guidance. This can be provided in three main ways, each of which has been used successfully.

Because many entrants to psychiatry have little understanding of scientific ideas, one form of preparation for research is through systematic instruction about these ideas and about research methods.

One method of achieving this is an analysis of questions that have led to successful investigations in the past. This kind of analysis can illustrate the need to formulate clear, simple questions; and it can be used to reassure the trainee that clinical studies can be based scien-

tifically and yield valuable information. In these discussions, considerable attention is usually given to research design because these are common to the many different kinds of research which may interest the trainees later. On the other hand, techniques of measurement are taught best in relation to specific projects—though there are general principles about the reliability and validity of measurements which apply to all types of enquiry.

An interesting model of such a course has been developed by the University Department of Psychiatry, Manchester. This course took the form of ten weekly sessions each lasting for about two hours. The first session was introductory; each of the remaining nine was given by a different teacher who worked with a volunteer trainee. Each of the nine sessions was divided into two parts. In the first part the teacher spoke about the problems peculiar to the kinds of enquiry involved in his own research, with illustrations drawn from his personal work. He also drew attention to remaining problems of a kind which could be undertaken by a single research worker. In the second part of each session, the volunteer explained how he would attempt to investigate a problem which had been discussed in advance with the teacher. These problems were chosen to illustrate issues such as measurement and sampling. The nine sessions included research in the fields of physical illness, life events, alcoholism, psychopharmacology, addictions, psychotherapy, family relationships, children, and general practice.

These introductory seminars need to be followed by regular opportunities to review research in seminars and journal clubs, and backed up by regular tuition or supervision.

When the trainee has mastered these general principles, he is ready to proceed to the second stage of his research training, in which he learns through the experience of carrying out a small investigation himself, or of reviewing existing research on a particular topic. This is a difficult stage in training and it is made the more difficult by the lack of time available to the trainee. There are two ways of gaining this experience. First, the trainee can set aside some time each week over a period of, say, two years. This is the pattern that has long been adopted at the Bethlem Royal and Maudsley Hospitals and it has been followed elsewhere. Its advantage is that no special funding is required; its disadvantage is the difficulty of initiating research in such a part-time way. It is, nonetheless, the way in which most trainees must begin.

The second way of proceeding is for the trainee to obtain special funding to work full-time on a research project. The advantages of this are obvious; the disadvantage is that the public and private bodies which fund research generally support work taking one or two years,

and at this stage the trainee may be uncertain whether he wishes to interrupt his clinical training for that long a time. Recently, financial support from the Wellcome Trust has made it possible to explore the value of an alternative arrangement in the Oxford University Department of Psychiatry, at the Maudsley Hospital and at Edinburgh. This arrangement allows a proportion of trainees to undertake a six months period of research during their three years training leading to the membership examination. It was at first uncertain whether this period would be sufficient. Experience has shown that, provided the trainee works with an established research worker, it is possible to arrange projects which can be undertaken in six months, though the results may have to be written up later. While it has proved easiest to find suitable projects in psychopharmacology, some trainees have successfully completed a variety of clinical enquiries involving semi-standardised interviewing and epidemiological methods, psychological techniques and biochemical estimations. These have been applied to clinical topics as diverse as deliberate self-harm, premenstrual tension, maternity blues, epilepsy, depressive disorders, and schizophrenia. The enthusiasm with which the scheme has been approached by trainees shows that at least some of the difficulties in encouraging research are related to the problem of making available the appropriate periods of time, at the right stage of training.

It can be argued that the best incentive to research is the opportunity to publish a paper and speak about original work at scientific or other meetings. A university degree is another incentive. For some this can be an MD, for a few a PhD, but for those who are unlikely to complete the substantial work required for a doctorate, a master's degree can provide a valuable spur. Degrees of this kind are at present provided in the Universities of Edinburgh (MPhil), Leeds (MMedSci), Liverpool (MPsychMed), Manchester (MSc) and London (MPhil). The preparation for these degrees is generally based on courses designed to prepare for the MRCPsych, with extra instruction available to those taking the degree. It appears that none of the degrees attracts more than half the candidates taking the basic course, and most attract relatively few candidates. This appears to be true even in the Institute of Psychiatry and at Edinburgh, with their long experience first with an academic DPM and then with an MPhil.

Although several universities now run courses leading to a master's degree they are available only to a minority of trainees in the country as a whole. For the majority it is important that the examinations for membership of the Royal College of Psychiatrists provide some incentive to become interested in research. The examination includes some questions designed to test candidates' knowledge of research methods and their ability to evaluate the research of others. It is

disappointing that the 'research option' of the membership examination has failed to be attractive to candidates. (This option allowed candidates exemption from one part of the examination in return for writing a dissertation about their research.)

Before leaving the topic of the research component of training for intending clinicians, it is appropriate to summarise a number of factors militating against research, most of which have been indicated already. These include: the heavy clinical duties of most training posts; the undervaluation of research by trainers; financial disincentive, arising from the payments given for additional hours spent in clinical work ('units of medical time') but not for additional hours spent in research; and the low value placed upon research experience by many consultant appointment committees. It is certainly desirable that experience in research is given appropriate credit in appointing senior registrars and consultants, at the very least in teaching districts.

Research training for university teachers and full-time clinical research workers

Here the role of the trainers and head of department is even more crucial in encouraging the trainee and helping him understand his potential as a research worker. These trainees should generally have less difficulty in finding opportunities for research. It should be possible for them to obtain one of the training awards provided by the Medical Research Council, the Wellcome Trust, or the Mental Health Research Foundation; or to enter a post of lecturer within a university department; or for a smaller number, to work in one of the MRC units. Unfortunately, these lecturer posts can no longer be relied upon to provide good research training. This failure results in part from the heavy demands made on the lecturer for the teaching of medical students, and for clinical work, in many university departments of psychiatry. In part it results from the training requirements of the Joint Committee on Higher Psychiatric Training which, although giving considerable importance to research in training, still requires that lecturers who are honorary senior registrars should undertake at least four sessions of clinical work. Nevertheless, despite these difficulties, a period in a clinical lecturer post, perhaps followed by further training in a full-time research post as a 'fellow', provides a generally effective form of research training. For the career research worker this training should generally include a period in another department to learn about the modes of thought and techniques of investigation used in a different academic discipline.

The supply of training fellowships generally exceeds the demand

and the obstacles are of another kind: again some are financial. Despite the agreement of universities and the MRC to make extra duty payments, the aspiring research worker can still expect slower promotion to the consultant grade, and less opportunity for extra earnings when he is appointed. These obstacles are, of course, not limited to psychiatry; they apply to academic medicine generally. The other obstacle is the lack of senior posts in university departments. Without these, the smaller departments will continue to experience difficulties in supervising the research work of their lecturers and research fellows. The important initiatives of the Wellcome Trust in this direction have been valuable and deserve further encouragement. The DHSS could usefully review its contribution to the university departments to take account of the substantial amount of clinical work undertaken by university clinical staff who hold honorary consultant contracts. Further experiments along the lines of the joint appointments in the MRC's Clinical Research Centre (Crow and Booth, 1981) should also be considered. These matters have been discussed at greater length in Chapter 4.

EMPHASES

12.1 All clinicians require research training to develop an enquiring approach and to be able to evaluate scientific advances in psychiatry.

12.2 Consultants as trainers need to provide an example by their own concern with research.

12.3 Contact with a university department is necessary during general professional training and higher training, to provide links with those engaged in research.

12.4 All in training need to carry out an investigation under supervision or to review research in a particular aspect of psychiatry.

12.5 Experience in research should receive appropriate recognition by appointment committees for senior registrar and consultant posts.

12.6 Academic staff and other trainers of psychiatrists have responsibility of fostering the potential for research of those in training.

13 Specialty needs and general training

Introduction

The existence of separate specialties within psychiatry is often grounds for controversy and disagreement. Many psychiatric specialists will argue that the skills and knowledge they have acquired are essential for any who would aspire to practise psychiatry well. Should not every psychiatrist be something of a child psychiatrist? Is it not obligatory for all psychiatrists to be competent in the practice of psychotherapy? Is not the expertise of forensic psychiatrists basic to the knowledge and skills which should be acquired by all psychiatrists?

Given this hedging about the exclusive claims to expertise of full-time specialists, does psychiatry require more specialists, or more general psychiatrists of wide competence? The answer at present is probably both.

Full-time specialists will inevitably contribute much in the areas of teaching and research which only they can provide. There is likely to be a concentration of specialists in teaching centres and more psychiatrists with particular special interests in addition. A case can be made for the expansion of new NHS-funded academic posts in the psychiatric specialties, such as child psychiatry and mental handicap.

Outside the teaching centres there has to be adequate specialist experience available to meet service needs, but with the exception of child and adolescent psychiatry these needs could very often be met by general psychiatrists with special interests.

At the other end of the spectrum some would like to see an expansion of the specialties within psychiatry with the creation of full-time specialty posts in such areas as liaison psychiatry, and in alcohol and drug addiction. (The case for liaison psychiatry was argued in Chapter 10, for example.) A more general view perhaps, would be to prefer these not to be specialty posts, but rather to be special interest posts. The social and community psychiatry section of the Royal College recently produced a working party report dealing with the question: 'Should community psychiatrists be specialists?' (Royal College of Psychiatrists, 1982). The working party found no general support for the formal establishment of community psychiatry as a specialty within psychiatry but considered that psychiatrists in general should be better trained and better informed

about community psychiatry. This is also the opinion of other special interest groups about their own domain.

There have been recent suggestions that mental handicap should return closer to general psychiatry and be less a discrete specialty. Posts in mental handicap are notable for the fact that many do not attract many applicants or applicants of high quality. For this reason, posts in mental handicap may come to seem more attractive when combined with sessions in general psychiatry or child psychiatry (joint appointments with the latter specialty are certainly appropriate). However, it has been argued that with over 250,000 severely handicapped in the community (according to conservative estimates) and probably a similar number of mildly handicapped, there will continue to be a great need for psychiatrists with the specialised knowledge and experience of working full time with mentally handicapped people.

Flexibility in specialty training

There are probably several ways of coping with the increasing numbers of areas where specialist knowledge is required in psychiatry. There must be a high degree of cooperation between specialties and an emphasis on flexibility in training.

It should be possible for consultant psychiatrists to receive additional training in particular areas of special interest, maybe after seven to ten years in a particular post. This might well serve to increase job satisfaction as well as meeting service needs. Clearly training courses would need to be established and the consultant given adequate time off in the course of his other duties. At the level of higher training it has been suggested that 'credits' might be obtained in particular specialties, similar to the approach used by the Open University, after perhaps two years of training. Such credits might include recognition of research, and the opportunity for obtaining credits would of course not be confined to the period of higher training but available after it also. Some specialists would advance the counter-argument that two years is not time enough for a trainee to acquire the necessary knowledge and experience required of a specialist.

General training in the specialties

The problems inherent in specialisation within psychiatry will inevitably be reflected in training for general psychiatry itself. This is reflected in the sections below which contain basic recommendations for general psychiatric trainees in terms of goals and objectives. It would be almost impossible for even the best organised of rotational

training schemes to incorporate all the recommended experience in each of the specialties. Higher training provides the later opportunity when a trainee can complement what he has learned in general training by gaining experience in those special areas which he may have missed out on. Experience of the psychiatric specialties for general trainees recommended here may only sometimes be attained at present but should be accepted as an ideal.

Child and adolescent psychiatry

There are good reasons for believing that every psychiatrist should have some competence in child psychiatry (Krell and others, 1974). It is not easy to grasp fully the psychopathology of an adult patient without having a reasonable appreciation of the corresponding psychological processes in children. It is also difficult for general psychiatrists to avoid requests from time to time for advice and guidance on the handling of children and their problems; moreover, psychopathology in childhood often presents within a family where adult members have psychiatric disorders. (The importance of child psychiatry in the medical school curriculum was emphasised in Chapter 1.) Many psychiatrists working in the field of mental handicap or forensic psychiatry will need to have had experience of child psychiatry. There are strong arguments for a placement in child psychiatry being part of every psychiatric trainee's experience. Ideally, such training opportunity should be provided in hospitals or clinics where there is good liaison with medicine and paediatrics.

The broad goals of training are specified and the more detailed objectives expanded under each heading may be sub-divided into:

1 sound theoretical foundations; and

2 competence in basic clinical skills.

The following areas of knowledge, which could be considered basic to the practice of child psychiatry, include:

a. Theories of personality development, such as those of Piaget, Freud, Eriksen, and also modern learning theory, with particular reference to arrests or deviations in development.

b. Theories of the psychopathological origins of childhood disturbance which make possible an understanding of the origins of child disturbance in dynamic terms, such as infantile psychic trauma (Freud), attachment theory (Bowlby), and interactional theory (Chess).

c. The principles of clinical assessment of childhood disorder to be learned will include psychiatric examination of the child by special methods, for example, play therapy, interviewing parents and taking a social history, the interpretation of the information acquired, and training about the weight to be attached to the facts and understanding obtained. Knowledge of special investigations needs to be acquired as well, and will include psychometric and other psychological examinations, EEG investigations, and speech and language assessment. The relevance of the multidisciplinary approach to assessment is self-evident.

d. Multiaxial classification of disorder needs to be learned.

e. The important disorders of childhood and adolescence often present as clinical problems which are frequently less clear-cut in child psychiatry and different from those found in general adult psychiatry; they are often inseparable from family disturbance and educational difficulty.

Disorders in the areas of behaviour and communication need to be recognised; depression and suicidal behaviour, psychosomatic symptoms, disorders where social factors are of major importance, for example, deprivation in childhood, child abuse, and juvenile delinquency, and the effects of epilepsy or other cerebral dysfunction should all come within the trainee's general experience.

f. Treatment approaches with which the trainee needs to become familiar include:

i. Dynamic therapy (including play therapy and individual and group therapy);

ii. Family therapy (there is a need to recognise the impact of illness in one member of a family on the other members of the family, and general principles of the systems, strategic and structural approaches should be understood);

iii. Behaviour modification;

iv. Psycho-pharmacology in childhood and adolescence.

g. The psychological aspects of physical and mental handicap.

There is also a need to acquire basic understanding about child and adolescent patients detained under compulsion, and the ability to explain to them the basis of their detention, and also to other staff or members of their family. It is important that frequent reassessments of the continuing need for such detention should be made.

The trainee should be familiar with the problems associated with giving treatment to compulsorily detained patients, and should always be mindful of the patients' own rights. Aspects of such treatment changed when the Mental Health Act 1983 came into effect. The interplay of family, developmental and physical factors needs to be understood and interpreted in the light of theoretical knowledge to arrive at a diagnostic formulation.

a. Objectives have also to be met in the areas of treatment and management. These need also to be communicated clearly and appropriately to patients and their families.

b. There needs to be a good working relationship with colleagues in the allied disciplines already mentioned, such as social work and clinical psychology.

c. The ability to communicate perceptively and sensitively with patients, their families, and other agencies, is clearly a requisite of those practising child psychiatry, as much as in any other branch of psychiatry.

The above objectives are most likely to be achieved where there is adequate feedback and evaluation at all levels by both trainers and trainees. Basic clinical competence, the most important outcome of training, is the most difficult to assess.

Psychotherapy

The training needs in the area of psychotherapy are complicated by the fact that psychotherapy is difficult to define, it may be practised on a number of different levels, and psychotherapeutic skills are extremely difficult to evaluate. The complexities of interpersonal therapeutic relationships do not lend themselves easily to research, a fact overlooked by those who argue that the effectiveness of psychotherapy needs to be more fully proven in order for it to be taken more seriously by general trainees.

The Royal College of Psychiatrists (1971) has recommended that all trainees should have supervised experience of psychotherapy. It is recognised that training in psychotherapy poses particular problems and such training might not be available in many areas. The Royal College has recommended that with certain types of psychotherapy, continuity and experience with particular patients is essential, over at least two years. This ideal is probably rarely achieved outside of 'centres of excellence' and perhaps even there only by those trainees who have a particular interest in psychotherapy. The Royal College

recommends that every effort should be made to maintain continuity of training for individual and group psychotherapy and, if possible, trainees should treat a few individual patients under the supervision of psychotherapists, manage at least one small group, and have experience of wards run as therapeutic communities.

The effect of the College requirement on individual psychotherapy supervision was reviewed in one department, and evidence obtained that the implementation of the recommendations had led to a marked increase in trainee psychiatrists' involvement in supervised psychotherapy (Lund and Allison, 1978). It was also noted in this study that clinical psychologists and social workers at broadly comparable levels of psychotherapeutic experience were getting more supervision of cases than their psychiatrist colleagues.

The broad goals of general psychotherapy training can be considered as two-fold:

1 Theoretical goals

The trainee needs to become able:

a. To recognise the differences between, and the appropriate uses of, the various schools and types of psychotherapy.

b. To recognise the differing historical and theoretical foundations of the two major branches of specialised psychotherapy, that is, psychodynamic and behavioural psychotherapy.

c. To understand the principles of dynamic psychotherapy in terms of how disorder may arise from conflicts over unacceptable aspects of the self, which may be more or less unconscious because of the anxiety or psychic pain which they arouse. (The way that these may be dealt with by a variety of defence mechanisms which vary with the phase of personality development that the patient has achieved should be recognised.)

d. To comprehend the different forms of dynamic psychotherapy including individual, group, marital, and family therapies, some of which are based to a greater or lesser degree on principles derived from psychoanalysis.

e. To understand the basic principles of behavioural psychotherapy.

f. To grasp the essential features of these forms of therapy (which means their indications and limitations have also to be learned).

2 Clinical goals

a. To further his understanding of behavioural psychotherapy, a trainee should have the opportunity to devise and carry out a programme of behavioural psychotherapy with one or more suitable patients, under appropriate supervision.

b. To further his understanding of dynamic psychotherapy a trainee should have an opportunity:

i. To have one or more suitably selected patients in individual psychotherapy under the supervision of an experienced psychotherapist. Some would argue that this should be a specialist consultant psychotherapist, but in some areas this may not be possible and consultants with a special interest may be able to carry out the supervisory task satisfactorily. The use of consultant psychotherapists as trainers over an extended area, as peripatetic supervisors, has also been tried in some parts of the country.

ii. To undertake group psychotherapy (of both inpatients and outpatients), marital therapy and family therapy, either alone or as co-therapist, with adequate specialist supervision.

c. The practical experience so far indicated will familiarise the trainee with the problems of establishing and maintaining an effective therapeutic alliance, and make him aware of basic psychodynamic phenomena such as defence mechanisms, transference and counter-transference. Such phenomena will clearly be explored in detail in supervision.

d. In addition to supervised formal psychotherapy, the trainee should have an opportunity of case discussions and seminars to further his psychodynamic understanding of patients' problems and the doctor-patient relationship. This will inform his understanding of both general psychiatry and psychiatric liaison work. Without such an understanding, much of psychiatry remains a relatively meaningless subject, unappealing to those recruits whose ideal is to be more than technicians.

Mental handicap

The Royal College of Psychiatrists (1983) has recently published a document on the future of mental handicap services. Its purpose has been to review past policy statements 'in the light of their implications for the evolving practice of psychiatry and the training of psychiatrists in mental handicap'. Few could take exception to the conclusions

reached: 'The heterogeneous nature of the mentally handicapped population, and the multiplicity of their problems, requires a wide variety of skills and services to deal with these efficiently. At present there are a large number of patients in mental handicap hospitals who do not have psychiatric problems, and are the proper responsibility of other services. Mentally handicapped people, like others, need services which are social and educational in nature, but some of them and their families have a variety of problems which require psychiatric services and other medical services. The psychiatrist with special training in mental handicap would be in the best position to provide the clinical and management input. The training of such psychiatrists must cover the core areas described as well as particular subspecialties in order to provide a flexible service. The environment of all staff and patients must be of a high standard to improve both the quality and the numbers of professionals who work for the mental handicap service.'

Increasingly recognised is the fact that 'the presence of psychiatric disorder in a mentally handicapped person is often missed, misdiagnosed, or inadequately treated. In the case of a severely handicapped and inarticulate individual, diagnosis of such an illness may be very difficult. Whether it is detected and adequately treated depends on the observational skills and knowledge of those who are in the caring role' (Batchelor, 1982).

While recognising that the primary role of a consultant psychiatrist in mental handicap should be the provision of psychiatric care for mentally handicapped individuals and their families, such a consultant will inevitably have considerable management and administrative responsibilities in terms of coordinating other helping agencies for those people under his care. He may also need to play an important advisory role for many people involved with the mentally handicapped in the community. He will need to ensure the appropriate provision of medical, surgical, psychiatric and other care, and also be sensitive to both the needs and responses of families. His overall aim will be to help to develop the potential of each individual, and to help to create the best possible working environment for the mentally handicapped, wherever he may be working or living.

It is important that a considerable awareness of the needs of the mentally handicapped should be acquired at the stage of general professional training. Certain goals and objectives can be specified:

1 The trainee should acquire a thorough knowledge of the biological aspects of mental handicap; this will include genetics and biochemical disorders. Mental handicap is commonly associated with a variety of physical handicaps and in this context knowledge about

epilepsy and anti-convulsive therapy is clearly essential along with other aspects of organic psychiatry.

2 The trainee should gain understanding of the psychological, environmental, and social factors that promote mental health in the mentally handicapped. To this end the trainee should demonstrate that he is able to examine the various inappropriate life-styles provided for mentally handicapped people and the social and psychological stresses that occur as a result. He should be able to observe the ways in which intervention in families who receive help, by care staff and other professionals, can reduce the stress and improve the life-style of the handicapped. Ideally, there should be the opportunity for the trainee to work in various appropriate milieux such as day centres, group homes, and special schools, which are designed to encourage maximum development of skills and personality with the reduction of handicap to a minimum.

3 The trainee must understand the way in which the symptomatology of psychiatric illness is distorted by the presence of: (a) low intelligence; (b) the presence of other long-standing disabilities such as sensory or mobility deficits; (c) inappropriate and non-chosen life-styles.

Such understanding can be gained by developing the ability to obtain histories from mental handicapped people themselves, and from those who care for them, eliciting psychiatric symptoms and noting in detail their presentation and the repercussions of these symptoms on their life-style. In turn the altered life-style will have an effect on the symptomatology. This experience will be obtained by working in long-stay and short-stay units which admit mentally handicapped people, through work in the community with mental handicap teams, and through family therapy.

4 The trainee must develop the ability to modify treatment skills learned in general and child psychiatry, so that they become appropriate for mentally handicapped children and adults, and those who care for them, including their families and the staff of residential services.

These skills will include individual psychodynamic psychotherapy, group therapy of different kinds, behaviour therapy, family therapy, and the use of psychotropic medication, with particular emphasis on the variety of possible side effects of many drugs.

5 The trainee should gain knowledge of the psychopathology that may arise in caring groups with a handicapped member, most often

the nuclear family. This experience can clearly be best obtained by working with the particular groups concerned, but may also arise out of work with the community mental handicap teams.

The psychiatry of old age

A considerable increase in consultant numbers is likely to be required over the next 20 years to cope with the increase in the elderly population. The estimated increase in the number of over 85s of over 50 per cent before the end of the century is likely to place a considerable demand upon psychiatrists and other services. While an ideal number of consultants specialising in the care of the elderly might be recommended, general psychiatrists will inevitably see an increasing number of elderly people with psychiatric problems and this will need to be reflected in their general training.

The goals of training are indicated in the following five sections, with each goal expanded by more detailed objectives. The trainee will need to demonstrate ability:

1 To understand the nature and scale of changes in the number and proportion of the old and very old in the population. The reasons for these changes must be recognised, as well as their implications for health care and the support of the elderly.

A trainee should be familiar with published sources of routine statistics and be able to describe changes and projected changes in number and proportion of the elderly in Britain in the coming years. The reason for these changes may affect the use made of health and social services.

2 To understand the main social, psychological and biological factors which are involved in ageing, and to be able to recognise these in individual patients. Trainees should be familiar with current social, psychological and biological theories of ageing and recognise the wide variations which are found.

3 To diagnose accurately, and treat appropriately, common psychiatric disorders in the elderly, with due attention to their different presentations, natural history and responses to treatment:

a. In their clinical work trainees should learn to recognise the differences between the presentation and the natural history of common psychiatric disorders in the elderly from those in younger adults. Depressive illness, paranoid states and neurotic disorders may differ markedly in their presentation in the elderly.

b. The clinical features and pathology of the common organic

brain syndromes, together with their management should be well understood. Trainees should be able to distinguish between dementia and delirium, and it is important that experience of such conditions should be gained early in training.

c. Trainees should understand the different responses to drugs found in the elderly which may necessitate different regimes and dosages. The particular problems of drug compliance in the elderly must be recognised and the appropriate use of ECT understood.

4 To understand those aspects of general medicine which are particularly relevant to mental disturbance; this may be learned through collaboration with geriatricians and other physicians. Trainees should learn to recognise the non-specific presentations of disease in the elderly, and also the atypical presentations of common diseases. Appropriate management of the elderly will inevitably involve experience of collaboration with specialised medical and non-medical services.

5 To grasp the principles of planning and provision of psychiatric services and other services provided in the community for old people. Trainees should be familiar with the details of current 'norms' for services for the elderly and of the most commonly practised patterns of organisation of psychogeriatric services. This should include details of various policies and practices, and collaboration between psychogeriatric, social, and geriatric services, and the legal and administrative basis for the provision of these and related non-statutory services for the elderly.

Forensic psychiatry

Many would argue that forensic psychiatry is not a separate specialty, but that matters of concern to forensic psychiatrists are central to the knowledge and skills which should be acquired by any psychiatrist. However, others maintain that forensic psychiatry does require specific skills, which can only be properly acquired through intensive and prolonged experience. If all the proposed number of secure units are eventually built, with the care of dangerous patients being geographically spread more evenly around the country, then the most appropriate people to run these units will be those with adequate experience in forensic psychiatry.

The goals of general training in forensic psychiatry could be said to be broadly the same as those in general psychiatry but emphasis needs to be given to particular areas.

1 The trainee should be able to assess any potential threat which the patient poses to himself or to others. The intrinsic problems in assessing dangerousness are well known, and it must be recognised that this ability is only gained with time and experience.

2 Trainees should have witnessed the management of episodes of violence and clearly at times they will have had responsibility for patients who may threaten violence to themselves or to others. The need for detailed ward and hospital policies about the management of violence must be conveyed.

3 The ability to write concise reports on clinical cases which are free of jargon, and which contain information of practical value to the recipient is clearly particularly important in forensic psychiatry.

The language of court reports should be comprehensible to the layman and any recommendations made should be practical and realistic.

4 A trainee should know when, how, and why, to apply compulsory admission and treatment to a patient. The ability is needed to supervise patients detained under compulsion, and to explain to them the basis of their detention, and to other staff or members of their family. It is important that frequent reassessments of the continuing need of such detention should be made.

The trainee should be familiar with the problems associated with giving treatment to compulsorily detained patients, and should always be mindful of the patients' own rights. Aspects of such treatment changed when the Mental Health Act 1983 came into force and the Mental Health Act Commission is to produce new codes of practice. Experience should be gained of working in a closed ward setting and a trainee should become familiar with the indications for transfer to a secure ward, and this should include the transfer of patients to conditions of greater security. Much can be learned in this area by observing more experienced consultants in their assessments.

5 A trainee should have some experience of working in non-hospital settings, such as a local authority home, a remand home, a community home, borstal or prison.

6 The trainee should understand the ethical and legal context in which modern psychiatry is practised. He should be able to discuss the ethical pros and cons of any assessment or treatment procedure which he is considering. The importance should be prominent of evaluating each case individually. Trainees should have a thorough

working knowledge of the Mental Health Act, the court process, the disposals and particularly the psychiatric disposals available for offenders, the role of probation officers, and the use of probation with a condition of medical treatment.

EMPHASES

13.1 Specialists in particular areas of psychiatry have a major contribution to make in the areas of teaching and research, as well as service provision. Expansion of specialists in teaching centres could come through university initiative, and also through creating NHS-funded academic posts.

13.2 Much specialist work in psychiatry will need to be done by general psychiatrists with special interests.

13.3 There needs to be greater opportunity for specialist training in psychiatry. This must incorporate flexibility and the opportunity for training in a different sub-specialty after some years in a consultant post.

13.4 Goals are recommended for a general trainee's experience in five different specialty areas.

14 Overseas doctors in psychiatry

Introduction

Much has been written—and continues to be written—about the problems experienced by doctors coming from overseas to the United Kingdom for postgraduate training. These problems have included those due to culture shock (Cox, 1980), language difficulties (Mahapatra and Hamilton, 1974), and persistent examination failure (Hassall and Trethowan, 1976). A recent survey of psychiatric trainees successful in the November 1981 and April 1982 membership examination disclosed that 82 per cent of those who graduated in the UK passed at the first attempt, compared with 40 per cent of Asian candidates (Cox and Sagovsky, 1984). The root of the difficulty is that large numbers of overseas doctors are diverted from their original intentions by failure to obtain posts and then go into the shortage specialties including psychiatry (GB, Parliament, House of Commons, 1981) where the training they receive is less than adequate and in underprivileged hospitals; in consequence, 'the defects and deficiencies of the present system probably bear more hardly on overseas doctors who have great difficulty in securing appointments to posts which will provide a good training' (Royal Commission on Medical Education, 1968). The end result in one region was that a considerable number of overseas trainees had repeatedly failed to obtain postgraduate qualifications, and had moved from successive psychiatric registrar posts so that most were either not going to engage in or prove suited for professional training in psychiatry or gain an appointment to a consultant post (Stead and others, 1980). Although the hospitals in which these doctors worked may have mounted excellent teaching programmes, many of their consultants did not engage in day-to-day inservice training with their juniors.

Language and transcultural problems

An analysis of the performance of overseas graduates in the Leeds DPM (Mahapatra, 1975) disclosed no evidence that language difficulties impaired examination results. However, these doctors had been screened by being required to pass the Leeds University English test for foreign students before being allowed to enter the course. Reveley (1983) approached a number of consultants who had recently acted as examiners for the MRCPsych asking their opinion as to the

reasons why candidates failed: only six per cent identified transcultural or English language problems as a reason for failure—deficits which would be difficult to remedy. On the other hand, no fewer than 87 per cent regarded inability to present a coherent formulation after examining a patient as the chief reason for failure, a deficit reflecting on teaching received and one capable of being remedied.

In contrast, Smith (1980) presented a large number of overseas doctors with an objective test of command of English which concentrated on styles of English relevant to a doctor practising in England. He found that at least 13 per cent and possibly as many as one-third of overseas doctors had a significant linguistic handicap. However, the command of English of overseas doctors tended to improve rapidly as their stay in the UK extended; few of those who had been in the country for three or more years had a significant handicap. There was also a strong relationship between command of English and seniority in the hospital service, so that no significant language problem presented among senior registrars and above, or among general practitioners.

Prejudice

Assertions have been made that certain overseas doctors were kept in a position of disadvantage by the nature of institutions that employ them and by the medical hierarchy (Sashidharan, 1981); counterclaims have been made that overseas doctors had a less satisfactory undergraduate education (Lettin, 1981). It has been suggested that many overseas doctors who qualified after 1970 are less familiar with the English language and culture because of the loosening of ties between their countries and the UK (Perinpanayagam, 1973). That there are overall differences in competence between groups of overseas doctors is suggested by persistent discrepancies in the PLAB test pass rate (General Medical Council, 1979; 1981). Explanations for this finding would include selective migration as well as good grounding in English and better undergraduate education.

A detailed and wide-ranging study of the problems faced by overseas doctors in the NHS has been made by Smith (1980) on behalf of the Policy Studies Institute. Many of the doctors studied have been disappointed in their career choice and in their lack of success in obtaining qualifications and their progress through the career grades. A small proportion only—18 per cent—of the overseas doctors thought that racial prejudice had been an important factor discriminating against them in the selection procedures. Smith concludes that 'most of the inequities in the present system, from the perspective of overseas doctors, arise from structural factors rather than from individual acts or general policies of racial discrimination'.

Manpower considerations

For several decades the NHS has been heavily dependent on doctors from overseas to fill junior posts, particularly in the shortage specialties of psychiatry, anaesthetics and geriatrics. In general psychiatry, for example, there was a 25 per cent increase in the total numbers of trainees between 1965 and 1970, but at the same time there was a fall of 12 per cent in the number of British-born trainees, so that in the latter years overseas doctors formed 56 per cent of psychiatric trainees heavily concentrated in the registrar and SHO grades. Since 1970 the number of trainees in general psychiatry has doubled, but as more home graduates have been recruited the proportion of overseas doctors has fallen to 42 per cent, still with the largest proportion being in the registrar grade.

Ten years ago at least two-fifths of overseas doctors holding psychiatric posts came to the country with no intention of doing psychiatry (Brook 1973), but went into it because of difficulty in obtaining posts in the specialty of their first choice, usually in a peripheral hospital where—certainly until recent years—training opportunities have been less satisfactory than in teaching hospitals (Royal Commission on Medical Education, 1968).

Training opportunities

A series of surveys made at three-yearly intervals of recently appointed consultants in general psychiatry (Brook 1972; 1974a; 1977; 1981b) demonstrated that those who had trained at non-teaching hospitals felt that their experience had been less satisfactory than those who had obtained training in university centres; this group would include the majority of overseas doctors. There are, however, clear indications that the gap between the more and less favoured areas has narrowed considerably, particularly in the last three years, which must be due to the inspection and approval visits of the Royal College of Psychiatrists of general professional training posts and the Joint Committee on Higher Psychiatric Training of senior registrar posts. The most recent survey (Brook, unpublished) has also shown that by the end of their training period the majority (70 per cent) of the overseas group had spent part of their time in teaching and university hospitals. This compares with a figure of 91 per cent for home graduates. Another interesting finding from the recent survey is that this group of overseas doctors seems more committed to psychiatry than their predecessors, judged by the time when these doctors had made the decision to enter the specialty, and this was confirmed by the fact that there was little difference between them and the home graduates in time elapsing between entering psychiatry

and qualifying. However, it is unsafe to generalise too much about this group as they are not typical, in that they are the ones who have attained to consultant posts through a combination of intelligence, determination, perseverance, luck and good judgment, as well as having had better than average training.

The effects of the Short report

This is discussed in Chapter 16, section 5—'The Short report and manpower'. The reduction in the number of trainees in psychiatry can be expected to be relatively modest and should lead to loss of posts in those hospitals offering less than satisfactory training; the number of home graduates seeking psychiatric training may increase because of the reduction in training posts in the medical specialties and the likelihood of increasing competition for jobs in general practice.

Regulating numbers of overseas doctors

If numbers of overseas doctors coming to this country were to be regulated, and only those on sponsored training schemes admitted, the threat of medical unemployment will be reduced. Recent political policy statements indicate that medical school expansion will not now continue to take place. It was the view of the Council of the British Medical Association that 'it is unlikely that any government will introduce methods of regulating the number of overseas doctors who come to the UK and BMA Council do not wish special career posts to be created for overseas graduates' (British Medical Journal, 1983a). The General Medical Services Committee subsequently proposed that some form of control be introduced for practitioners from overseas who are seeking to enter this country to practice (British Medical Journal, 1983b).

The Medical Act of 1978 had introduced a new system of recognition for full registration by the General Medical Council of the degrees of some Commonwealth universities; limited registration was extended to a much wider group, including India and the Middle East. Limited registration entitles a doctor to an aggregate maximum period of five years. Over the past five years one-third of all doctors on limited registration transferred to full registration, almost all with the intention of staying in the UK.

New immigration rules now being introduced will have an important consequence for this group of overseas doctors. The effect cannot at present be predicted with certainty, and will be gradual. Improved training facilities will be needed in the future for overseas doctors on the limited register who now have no more than four years to remain in the country.

Sponsorship

A working party of the Council for Postgraduate Medical Education in England and Wales (1983) has produced proposals for a national sponsorship organisation which would help overseas qualified doctors to obtain appropriate training and qualification and which would involve selection for sponsorship, supervised training in the UK and return home on completion of training. This document is being circulated for discussion. One proposal that 'the training should be demonstrably superior to that available to self-selected non-sponsored overseas doctors' might well be regarded as divisive by creating a two-tier grade of training.

There is clearly a need for a sponsorship scheme, and if this was not to be undertaken nationally, then the royal colleges, universities or district health authorities should provide schemes of their own. A sponsorship organisation inevitably costs money, and the colleges could only find the necessary resources by charging a fee; some countries were often not willing to pay such a fee and it would be important that contributions required could to some extent subsidise poorer countries.

EMPHASES

14.1 Selection

It is important to be selective in the appointment of overseas trainees and to appoint to training grades only those who possess the necessary personal and professional qualities making them suitable for training. The practice has to be abandoned of appointing overseas doctors purely for service purposes to the purported training grades in hospitals which do not provide adequate training and supervision. Other methods must be found of undertaking the medical work in these hospitals.

14.2 Psychiatric tutors

Psychiatric tutors are important in that they are in the position to offer a great deal of help to the overseas trainee. Overseas trainees have to recognise this and seek the tutor's advice and counsel if and when necessary. Psychiatric tutors need to take particular interest in overseas trainees and should be concerned about their special difficulties in training and clinical practice. It will be of particular benefit if tutors are accurate in the comments they make on trainees' clinical work and progress in training, and of their suitability to take the membership examination.

14.3 Acquisition of clinical skills and theoretical knowledge

All trainees whether home or overseas graduates should endeavour to acquire the necessary clinical skills and theoretical knowledge for good psychiatric practice during their general professional training, instead of being narrowly preoccupied with postgraduate examinations.

14.4 Practical help

Assistance in the writing and presentation of good case histories is desirable. The overseas trainee needs to be helped with practical advice in respect of courses, examinations, job seeking (Mahapatra and Burma-Wilson, 1980) and housing.

14.5 Contribution of overseas doctors who are consultants and senior registrars in psychiatry

It should be remembered that 19 per cent of consultants and 38 per cent of senior registrars in psychiatry in England and Wales are doctors who were born and qualified overseas. These more senior doctors can make special contributions towards improved training of the younger psychiatric trainees from overseas.

14.6 Devising a fair system and helping to improve training

A fair system of selection, access to rotational training schemes and postgraduate education will improve the psychiatric service in the NHS, and will curtail the personal hardship which some overseas doctors faced. That this can be achieved is evidenced by the real concern which exists within the medical profession, but it will need the allocation of additional resources by the government, so that clinical attachment schemes for overseas doctors can be improved and good professional training can be available to all trainees in psychiatry. The General Medical Council will now grant only limited and not full registration to graduates from more of the Commonwealth countries (including India and the Middle East). In addition, details of new immigration rules are awaited. It can be expected that overseas trainees will be much fewer in number, and many able to stay only four years on limited registration. They should be provided with sponsorship from the Royal College and from the training schemes they enter.

14.7 Remedial action

Overseas doctors failing to progress through the grades or to pass examinations must be identified as early as possible. Provision should

be made for this group to have counselling and, if necessary, special educational facilities; there may be merit in appointing a tutor with special responsibility for overseas trainees in each region.

14.8 **Raising training standards**

The best hope for improving postgraduate training for overseas doctors is by continuing the general raising of training standards in psychiatry. The proposal that approval of hospitals be replaced by approval of programmes of training involving particular posts and requiring an associated academic course, will greatly facilitate this progress. The approval and inspections of the College and JCHPT will continue to improve educational facilities and raise the level of training.

15 Women in psychiatry

Introduction

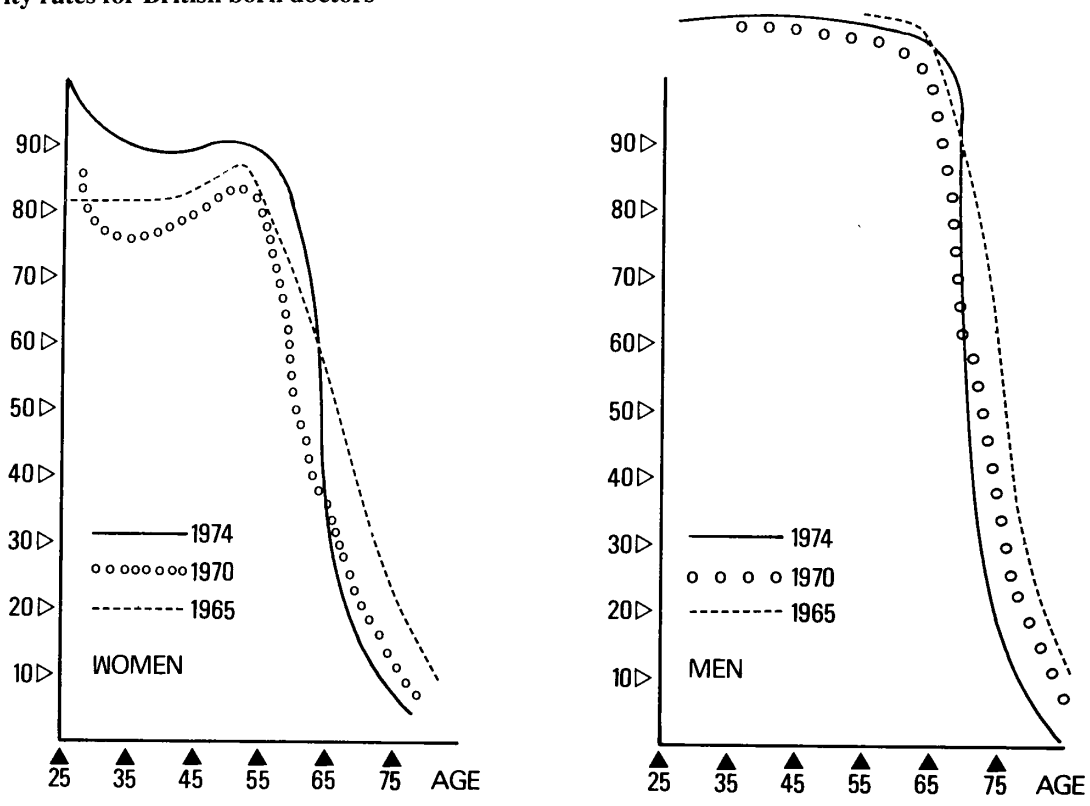
Psychiatry has always attracted a larger proportion of women than most other specialties, although general practice or community medicine are still more popular with women. The changing role of women, in society and within the medical profession, adds greater uncertainty to the difficult task of medical manpower planning. Women are also well represented in other hospital specialties, such as anaesthetics, radiology and pathology. Recently more traditionally male preserves, such as obstetrics and gynaecology, paediatrics and general medicine, have been recruiting more women (Table 7, page 148). If this trend continues it has major implications for recruitment to psychiatry, particularly if pressure from female recruits results in greater flexibility in training requirements and working conditions in the traditionally male-dominated specialties, thereby making it easier for women to enter the specialties previously less popular with them.

The sex ratio in medicine as a whole has been narrowing, particularly over the last decade since entry quotas restricting female entrants were lifted and sex equality legislation was introduced. It is anticipated that by 1985 equal proportions of men and women will enter the medical schools. Table 6 (below) shows the total stock of doctors in the UK and demonstrates that the proportion of female doctors is expected to continue increasing from 22 per cent in 1975 to 41 per cent by 2000. The loss of doctors through failure to qualify in

Table 6 Projected stock of British born doctors active in medicine

	Active stock (000)					
Year	*Numbers*			*Whole-time equivalents*		
	Male	*Female*	*Total*	*Male*	*Female*	*Total*
1975	42.2	11.8	54.0	41.0	9.1	50.1
1985	46.6	18.6	65.2	45.3	14.7	60.0
1990	47.7	23.6	71.2	46.4	18.6	65.0
1995	48.4	28.8	77.2	47.2	22.6	69.9
2000	49.7	33.9	83.6	48.5	26.5	75.0

Figure Activity rates for British born doctors



Source: 1965 data from Todd Commission: 1970 and 1974 from CMRC Index. Figures are for the percentage in each age group. The 1965 figures were collected on a different basis from later years.

medicine is higher for males than females (8.4 per cent compared with 6.5 per cent); male doctors are twice as likely to die before the age of 65. Women, however, are somewhat more likely to emigrate early in their careers but are also slightly more likely to return to the UK, and earlier than male emigrant doctors do. These losses are relatively small compared to the professional inactivity due to domestic commitments among women (Figure, opposite).

Contrary to the popular belief that women hospital doctors work few sessions, DHSS statistics in 1980 show that the average number of whole-time equivalents worked by women is 0.90 compared to 0.97 for males. Predictions about the work pattern of female doctors are unreliable—but by 2000, 65 per cent of female doctors are expected to be working full time. Thus any major shift in career choice of women doctors from the small sessional appointments in general practice, community medicine and clinical assistantships to career posts in hospital medicine may significantly alter the contribution and patterns of work of both sexes in hospital medicine. Changes in child-rearing practices, particularly within medical marriages, or a possible reduction in hours worked in all medical specialties which cannot be predicted, would also dramatically affect these forecasts and have repercussions for manpower in psychiatry.

Women working in psychiatry

DHSS figures (Table 7, page 148) show that while only 20 per cent of consultant psychiatrists are female, women make up 32 per cent of those entering psychiatry at senior house officer level. The lower proportion of women in senior grades is largely a reflection of lower female student intakes in the past, but it also represents some loss of trained or partly-trained female psychiatrists. How great this loss is and its causes are unknown. Many women take longer over their training because of domestic commitments. Women may choose to work long term as clinical assistants rather than become consultants or they may be discriminated against for promotion. Certainly 50 per cent of clinical assistants in psychiatry are women, so that the specialty has more than twice as many clinical assistants as any other. Since most are aged over 40, the grade may attract a proportion of women returning to medicine after raising their children, but over half work full-time and the number of whole-time equivalents worked by each differs little from medicine overall. The grade may offer greater flexibility of hours and the opportunity to work part-time, but women may be forced into this grade because of a shortage of part-time consultant posts in psychiatry. Currently a third of both male and female consultant psychiatrists work part-time although

Table 7 Hospital medical and dental staff: analysis by specialty, sex and grade, showing number of staff in post at 30 September 1981

Specialty	*Consultants and SHMOs with allowance*			*Senior registrars*			*Registrars*			*Senior[2] house officers*		
	Both	*M*	*F*	*Both*	*M*	*F*	*Both*	*M*	*F*	*Both*	*M*	*F*
All specialties	13,065	11,580	1,485	3,074	2,456	618	5,989	4,732	1,257	10,049	7,477	2,572
General medicine	1,058	1,011	47	215	205	10	662	565	97	1,039	766	273
Geriatric medicine	424	386	38	93	79	14	207	176	31	734	572	162
Ophthalmology	406	383	23	86	71	15	124	100	24	306	248	58
Paediatrics	527	440	87	151	106	45	249	165	84	942	578	364
General Surgery	949	940	9	196	196	—	689	651	38	672	633	39
Traumatic and orthopaedic surgery	659	656	3	136	134	2	358	350	8	660	630	30
Anaesthetics	1,687	1,358	329	387	275	112	832	609	223	916	609	307
Radiology	852	732	120	212	155	57	242	168	74	6	2	4
Gynaecology and obstetrics	717	634	83	128	112	15	469	347	122	1,254	788	466
Haematology	340	292	48	129	80	49	93	53	40	56	36	20
Histopathology	564	491	73	112	68	44	78	50	28	26	15	11
Mental handicap	158	120	38	20	17	3	41	26	15	16	112	4
Mental illness (adult)	1,102	946	156	300	223	77	730	500	230	798	540	258
Child and adolescent psychiatry	312	193	119	84	47	37	25	14	11	3	2	1
Forensic psychiatry	18	15	3	9	8	1	3	—	3	—	—	—
Psychotherapy	75	61	14	22	13	9	6	4	2	11	10	1
Total psychiatry	1,665	1,335	330	435	308	127	805	544	261	828	564	264

Source: *Health Trends*, 1982, 14, 29.

the men tend to work more whole-time equivalents than the women.

What attracts women into psychiatry?

In considering the future contribution of women to psychiatry, identification of the factors which attract women into the specialty is crucial. Working conditions are perhaps most important.

Trainees in psychiatry work fewer contracted working hours than in any of the other major specialties (under 70 hours compared with 80–100). The working hours are more flexible and with less on-call duty, which can more often be done from home. The current position of many unfilled posts in psychiatry favours recruitment of women, in that more posts are immediately available for women who move with their husbands' jobs, and more rapid promotion allows women to postpone childbirth until they are trained and established in their careers (Tables 8a and 8b, pages 150 and 152). Despite this, between September 1978 and 1979, only three women under 35 and six under 40 were appointed as consultants compared with 18 and 22 men.

Opportunities for part-time training are somewhat better at present in psychiatry and the DHSS figures show that it has more part-time senior registrars and registrars, mostly in supernumerary posts, than any other specialty. However, anaesthetics, paediatrics, radiology and pathology also have increasing numbers of such appointments and greater flexibility of training requirements than formerly. The more structured and formal postgraduate training now required for general practice may make a larger number of female recruits available for psychiatry. The Royal College of Psychiatrists allows reasonable latitude in part-time training and in the development of special interests. The above factors are particularly important in the psychiatry of mental handicap and child psychiatry which have consistently attracted more women (Table 7, opposite), and have lost fewer before appointment to the consultant grade.

Finally, one factor which may be very important is that women enjoy the nature of psychiatric work. A survey of trainees showed that 61 per cent of women compared with 50 per cent of men give this as the reason they chose a career in psychiatry.

Some identified problems and possible remedies

Particularly if working conditions and training requirements alter in favour of women in the other branches of medicine, attention must be focused on the difficulties experienced by women in psychiatry. These have been described and recommendations made repeatedly over the years; they include the shortage of part-time appointments

Table 8a Consultant appointments, 1980–81

Specialty	Number of posts					Successful candidates				
						Preceding grade				
	Total analysed	Total unfilled	Candidates per post	% Female	% Overseas graduates	C	SR (NHS-paid)	Other	Years as SR (mean)	Age if first C appointment (mean)
All hospital specialties	996	285	2.2	13	18	78	442	161	3.0	35.6
Anaesthetics	141	36	1.6	16	20	5	92	8	2.7	34.2
General medicine	67	10	4.0	9	7	5	34	18	3.8	34.2
General surgery	36	0	4.7	3	0	3	22	11	3.9	36.3
Geriatric medicine	37	13	2.0	4	42	2	18	4	2.2	35.3
Gynaecology and obstetrics	33	1	4.0	7	13	3	19	10	3.2	35.6
Haematology	24	6	1.9	28	11	2	8	8	3.6	33.6
Histopathology	49	20	1.4	21	14	5	8	16	3.6	37.4
Ophthalmology	23	3	2.8	10	35	3	15	2	3.3	38.1
Paediatrics	32	5	2.3	11	11	1	15	11	3.0	35.8
Radiology	120	68	0.9	10	29	8	33	11	2.6	36.0
Traumatic and orthopaedic surgery	33	0	3.3	3	9	0	29	4	3.0	36.0
Mental handicap	41	32	1.0	67	33	1	4	4	2.3	40.1
Mental illness (adult)	106	32	1.8	19	26	14	40	20	2.7	36.4
Child and adolescent psychiatry	40	17	1.5	39	17	6	14	3	3.3	37.8

Source: *Health Trends*, 1982, 14, 30.

or shared posts especially at consultant level, the shortage of creche facilities, and a relatively inflexible length of training required before trainees can sit the membership examination.

Part-time employees often lack financial allowances, and access to educational facilities enjoyed by full-time colleagues, and may have been unable to work for long periods while waiting for supernumerary PM(79)3 posts to be set up. Maternity leave regulations make a gradual return to work impossible after childbirth and there is no tax allowance towards the cost of childcare. There is little counselling for women (or men) in psychiatry, an emotionally demanding career leading to conflict with the demands of family life. Even in psychiatry, those who reach the top of the profession tend to work excessive hours voluntarily and to put work before family life. Those in part-time supernumerary posts sometimes experience resentment from their full-time colleagues, as part-timers may have no emergency or on-call commitments. As these posts are not advertised they may be seen as 'getting in through the back door'.

Full-time posts which cannot be filled have not been used resourcefully enough: alternative arrangements should be considered more often, such as two 'time-shared' jobs suitable for two doctors with domestic commitments, or one part-time job with enough sessions to meet local needs.

It is important to emphasise that although the above considerations have referred to women, they can equally well be applied to men with domestic commitments. There are a few men in supernumerary posts at present but it is impossible to predict how child rearing roles will change. If women doctors continue to be increasingly employed in psychiatry it is uncertain what the effects will be if men come to be a minority within the profession. It can be expected that if psychiatry pays attention to the needs of women doctors there will be at least the same proportion of women in psychiatry as in medicine as a whole. Women will therefore make a greater contribution to hours worked and fewer trained women will be lost to the profession. Gradually the proportions within the grades will even out, although there probably remains a place for a clinical sub-consultant grade for men and women who do not wish to have the clinical load and administrative responsibilities of a consultant post. Finally, the right balance has to be found between time taken off work or extended part-time work and opportunites for promotion.

EMPHASES

15.1 In the future the role of women in psychiatry will present many challenges. In some areas training schemes for women are well

Table 8b Senior registrar appointments, 1980–81

	Number of posts					*Successful candidates*				
						Preceding grade				
Specialty	*Total analysed*	*Total unfilled*	*Candi-dates per post*	*% Female*	*% Overseas graduates*	*Registrar*	*?? (NHS-paid)*	*Other*	*Years as R (mean)*	*Age if first SR appoint-ment (mean)*
All hospital specialties	557	70	3.7	17	21	24	353	110	2.8	31.9
Anaesthetics	86	0	3.0	17	10	3	68	15	2.5	31.1
Dermatology	8	0	3.0	38	13	1	5	2	2.1	30.3
ENT surgery	11	0	5.0	9	18	1	9	1	2.3	29.4
General medicine	29	0	5.0	9	18	1	9	1	2.3	29.4
General surgery	24	0	9.7	0	0	0	4	20	4.2	32.1
Geriatric medicine	41	11	3.4	13	40	1	23	6	2.9	32.7
Gynaecology and obstetrics	16	0	6.6	13	6	0	12	4	3.9	33.4
Haematology	12	0	5.9	33	0	0	12	0	1.8	29.3
Histopathology	21	6	2.4	20	13	1	10	4	1.8	28.8
Ophthalmology	14	3	4.0	18	27	1	8	2	2.8	30.6
Paediatrics	12	0	5.5	25	8	0	6	6	3.3	32.5
Radiology	54	8	2.0	28	22	4	41	1	2.0	31.4
Traumatic and orthopaedic surgery	14	1	7.6	0	8	0	11	2	3.7	32.1
Mental handicap	19	8	2.1	9	73	0	10	1	3.2	37.6
Mental illness (adult)	48	2	2.8	22	35	2	40	4	3.0	32.1
Child and adolescent psychiatry	33	9	2.0	29	46	3	20	1	3.1	34.1

Source: *Health Trends*, 1982, 14, 30.

established which allow them to work part-time, and these schemes seem to be functioning satisfactorily; a greater problem is to find permanent posts for those who have completed training. The assumption must be that these women will seek consultant posts and employing authorities or local consultants should be encouraged to make suitable posts available.

15.2 Wider training opportunities are needed for women seeking a career in psychiatry. In particular, the issue of splitting posts to suit the needs of doctors who could only offer to work part time should be discussed with the DHSS and its counterparts. Ideally, split posts are required, each of which could stand on its own. There remain many difficulties at present. It is also important to maintain the principle of open competition for posts.

15.3 There is uncertainty about how much implementation of the Short report will affect the training opportunities for women, if the number of training posts were to be reduced. It is important to maintain flexibility in the training, taking into consideration the two factors that women need to be geographically mobile, and to undertake training over a prolonged period part-time.

15.4 Attention should be given to the pressure on PM(79)3 posts (part-time training posts for doctors with domestic commitments) which are linked to the number of full-time posts. There are not enough PM(79)3 posts available. In addition to having to wait a long time for them, there was often competition for those becoming available.

16 Manpower

1 The present facts

a. *How many psychiatrists are there?*

Table 9 (opposite) summarises the position as at 30 September 1980 (GB, DHSS, 1980). The 3,841 psychiatrists comprise 11 per cent of all hospital medical staff in England and Wales, and one in four medical assistants work in this field. There are 1,475 consultants to 2,446 non-consultant staff.

Many junior staff are unable to leave their grade in the customary time (Table 10, page 156). Advertisements of vacant posts are often delayed, sometimes because of financial constraint; other reasons include inadequate quality for promotion, interrupted training periods (mainly married women), and deliberate choice of delayed promotion. For example, 26 per cent of registrars in mental handicap entered that grade more than four years previously and when the characteristics of these 'long term registrars' are examined closely, it becomes clear that many of them are not in training, have no intention or prospect of eventually attaining a consultant post, and are fulfilling mainly service needs. In addition, an unknown proportion of senior house officers are not seeking a career in psychiatry, but are gaining experience particularly for general practice. Finally, psychiatrists are not evenly distributed around England by population or by workload (Table 11, page 157).

b. *What are the characteristics of senior registrars in psychiatry?*

Of the senior registrars surveyed in 1978 (Brook, 1978), 24 per cent did not intend to get a general psychiatry consultant post in the United Kingdom. Half of those currently working or having trained in a psychiatric hospital wanted a consultant job in a psychiatric hospital, and half of those trained at the Maudsley Hospital in London wanted a post in a teaching hospital. Many said they would emigrate permanently if they did not get a consultant appointment in reasonable time, while very few would consider a non-consultant post. Follow-up investigation showed a close match between aspirations and actual consultant jobs—and there was particularly good matching between intention and outcome in the geographical area of work. Significantly, two-thirds of the newly promoted consultants

Table 9 Staff by grade and sub-specialty

	All staff[1]		*Consultant and SHMO*		*Associate specialist*		*Senior registrar*		*Regis-trar*	*SHO*	*Pre-reg HO*	*Hospital prac-titioner*		*Para 94 appoint-ment*	
	No	*Wte*[2]	*No*	*Wte*[2]	*No*	*Wte*[2]	*No*	*Wte*[2]	*No*	*No*	*No*	*No*	*Wte*[2]	*No*	*Wte*[2]
Mental illness	3,017	2,826	1,091	1,010 +31	203	182 +4	288	231 +8	691 −9	738 +78	1	53	16 +4	634	223 −12
Mental handicap	277	263	153	149 +2	37	30 +3	21	20 −5	48 +6	16 +7	1	4	1	208	68
Child and adolescent psychiatry	418	373	296	264 +18	4	3 +1	76	67 −8	25 −11	16 +2	0	5	1	50	16
Forensic psychiatry	28	22	18	13 +1	0	0	8	7 +4	1	0	0	0	0	2	1
Psychotherapy	101	77	58	39 +7	2	2 −2	18	16 +2	6 +2	17 +10	0	2	1	12	3
All psychiatry	3,841	3,561	1,616	1,475 +63	246	217 12	411	341 +1	771 −12	787 +97	2	64	19	906	311
All hospital specialties	35,352	33,257	12,840	11,748	1,039	857	2,968	2,558	5,879	9,681	2,817	732	187	6,965	1,684
% of all hospital specialties in psychiatry	11	11	13	13	24	25	14	13	13	8	—	8	10	13	18

1 Including post-registration house officers and 'other staff', excluding hospital practitioner and Para 94 appointments.
2 All wte rounded to nearest integer.
Source: DHSS Manpower Tables as of 30/9/80.

Table 10 Percentage of junior staff by duration in grade

	% Years since first entry to grade (1980)[1]		
	Senior registrar[2] *4+ over*	*Registrar 3+ over*	*SHO 2+ over*
Mental illness	8[3]	27	31
Mental handicap	14[4]	37	44
Child and adolescent psychiatry	11[5]	36	19
Forensic psychiatry	0/8	0/1	0/0
Psychotherapy	6[6] (1/18)	1/6	4/6
All psychiatry	7	28	31
All specialties	11	23	31

1 No account is taken of breaks since first entry to grade or of number of sessions worked per week.
2 Excluding honorary senior registrars and overseas staff of at least SR status holding a post in this country for only 1 or 2 years.
3 Five of these 17 were born overseas.
4 3/12: all 3 of these were born overseas.
5 One of these 8 were born overseas.
6 Not born overseas.
Source: DHSS Manpower Tables.

were working in the same part of the country in which they had worked as senior registrars.

c. *Overseas doctors in psychiatry*

Table 12 (page 159) demonstrates that overseas doctors make a proportionately greater contribution to specialties such as anaesthetics, geriatrics and mental health and the proportion in psychiatry has increased.

At least two-fifths of overseas doctors arrive in Britain with no intention of doing psychiatry (see Chapter 14), but enter into the specialty because of difficulty in obtaining posts in other medical specialties (GB, DHSS, 1978; Hasan, 1971). Furthermore, they have great difficulty in psychiatry in obtaining posts in major centres and are forced to take posts at the periphery. Once in psychiatry the majority, like their home-born colleagues, stay in the specialty although just over half intended to leave the UK, most to return to practise in their country of origin. Thirty-three per cent of overseas

Table 11 Consultant workload by regions: 1978[1]

Region	*Wte consultant/ 100,000 population (rank)*	*Admissions/ consultant (rank)*	*Residents/ consultant (rank)*	*OP attendances/ consultant (rank)*	*DP attendances/ consultant (rank)*	*Total rank*
Yorkshire	1.69 (2)	243 (1)	113 (2)	1755 (7)	4298 (2)	14
Trent	1.57 (1)	210 (3.5)	93 (4)	1857 (4)	3606 (5)	17.5
North Western	1.83 (5)	210 (3.5)	80 (10)	2175 (1)	4362 (1)	20.5
Mersey	1.73 (3.5)	241 (2)	135 (1)	1740 (9)	2709 (10)	25.5
East Anglia	1.73 (3.5)	193 (5)	85 (7)	1746 (8)	2873 (8)	31.5
Northern	2.00 (9)	188 (7)	88 (5)	1756 (6)	2830 (9)	36
South East Thames[2]	2.01 (10)	187 (8)	86 (6)	2077 (2)	2430 (13)	39
West Midlands	1.86 (6)	177 (9)	76 (11)	1614 (11)	4272 (3)	40
South Western	1.89 (7)	189 (6)	83 (9)	1204 (14)	3291 (6)	42
South West Thames	2.54 (14)	164 (11)	95 (3)	1993 (3)	2590 (12)	43
Oxford	1.94 (8)	140 (14)	49 (14)	1517 (12)	3950 (4)	52
North East Thames	2.40 (12)	157 (12.5)	70 (12)	1822 (5)	2616 (11)	52.5
Wessex	2.25 (11)	175 (10)	65 (13)	1245 (13)	3285 (7)	54
North West Thames	2.48 (13)	157 (12.5)	84 (8)	1644 (10)	2174 (14)	57.5

1 Activity figures are provisional.
2 Excluding postgraduate teaching hospitals.
Source: DHSS Manpower Return, September 1978; Mental Health Enquiry 1978; Facilities Return, 1978.

doctors are dissatisfied with their job opportunities, compared to 12 per cent of home graduates (Smith, 1980).

Although vacancies remain unfilled (Table 13, page 161) overseas doctors experience difficulties in getting posts. Overseas doctors make five times as many applications as British doctors.

2 How many psychiatrists are needed?

The first, and perhaps the main difficulty in answering this question is the definition of 'need'. Early manpower reports took existing doctor-to-population ratios and extrapolated them on the basis of changing population sizes, to obtain future needs. This method of calculation must result in the perpetuation of imbalances already present, favouring areas of the country which are already well staffed, and reflecting outmoded styles of psychiatric practice.

The other way of defining 'need' is by assessment of the theoretical need for medical—or in this case psychiatric—care, for example, by estimating the workload generated per head of population, and the amount of time needed by a particular doctor to complete a particular item of work. The number of doctors 'needed' can then be calculated. Intrinsic in this method is the difficulty in estimating the amount of time needed to perform a certain task, and this is compounded by the flexible nature of medical work, with junior staff assisting consultants to an unquantifiable and varied degree.

In 1973 the Royal College estimated norms based on 'true demand' (Royal College of Psychiatrists, 1973) by calculating the number of sessions required to carry out the clinical work performed each year according to the *Digest of Health Statistics*. This totals approximately 500 sessions per year or ten sessions per week per consultant, assuming that junior staff assisted mainly with inpatient care. To allow time for administration, teaching, research and so on, it was felt that seven sessions should be devoted to clinical work and to achieve this figure would require a 55 per cent expansion of the consultant grade, resulting in a norm of five whole-time equivalents (wte) per 200,000 population (200,000 is the population of the average district) or one whole-time equivalent consultant per 40,000 population. The DHSS agreed to aim to achieve this figure by the early 1980s.

The Royal College's original calculations were somewhat less than realistic. For example, in calculating outpatient workload, it was assumed that the consultant sees seven new patients and 42 follow-up patients each week, and that junior staff see none. These figures have been accepted by the DHSS nevertheless, and it would seem pragmatic to base future norms on those calculated in 1973. Since then, there has been a certain amount of 'leap-frogging' with the DHSS so

Table 12 Percentage of psychiatry staff born overseas*

% born outside UK or Eire	*Consultant*	*Associate specialist*	*Senior registrar*	*Registrar*	*SHO*	*All staff*
Mental illness	24	43	36	64	50	42
Mental handicap	30	43	76	83	87	48
Child and adolescent psychiatry	20	0/4	28	60	31	24
Forensic psychiatry	6(1/18)	0/0	2/8	0/1	0/0	11
Psychotherapy	29	1/2	22	0/6	65	30
All psychiatry	24	43	36	65	50	40
All hospital specialties	16	40	25	54	48	32
Anaesthesia	15		26	62	58	
Geriatrics	40		55	81	77	

* Excluding Hospital practitioners and Para 94 appointments.
Source: DHSS Manpower Tables 1980.

that although the original norms have nearly been reached, the Royal College has since proposed (Royal College of Psychiatrists, 1977) that the long-term goal should be eight whole-time equivalents per 200,000 and—based on submissions by each specialty—has broken down these norms per specialty (Table 14, page 162).

Following this, the College with the Association of University Teachers of Psychiatry (Royal College of Psychiatrists, 1978) recommended that this long-term goal of one whole-time equivalent psychiatrist per 25,000 be accepted as the interim goal in teaching districts, in other words that teaching districts should have 1.6 times the staffing level of non-teaching districts. This 'teaching increment' (and the long-term goal of one wte per 16,000) was based mainly on the additional undergraduate and postgraduate teaching and research undertaken by teaching hospital consultants.

3 Psychiatric specialties

The need to fill existing posts, and to create new ones, receives much emphasis in the information on the present position of the psychiatric specialties, currently being collected by the Manpower Committee of the Royal College of Psychiatrists.

a. *Child and adolescent psychiatry*

In spite of a 53 per cent increase in consultants between 1970 and 1979, many posts remain unfilled, and a further 70 posts are needed to meet the College's immediate target. Ten further senior registrar jobs are needed to correct regional maldistributions.

b. *Psychotherapy*

The Royal College's immediate aim of five sessions per 200,000 of population implies 114 whole-time equivalents in England and Wales. The latest National Tables show 38.8 wte and although this is an underestimate, there is room for expansion at consultant level (seven regions still have one or less consultant in this specialty). A survey by the psychotherapy specialist committee of the College recently identified 82 psychotherapy posts, many of which are part-time.

c. *Forensic psychiatry*

In 1980, there were eight senior registrars in post, with two still available positions unoccupied. If all the proposed number of secure units are eventually built, another 30 consultants will be needed.

Table 13

	Consultants				*Senior Registrars*			
	Total no posts advertised	*% Unfilled*	*Candidates per post*	*Years as SR of successful candidate (mean)*	*Total no posts advertised*	*% Unfilled*	*Candidates per post*	*Years as registrar of successful candidate (mean)*
Mental illness	107	35	1.5	2.1	57	11	2.1	3.0
Mental handicap	47	77	0.6	2.0	16	50	0.9	2.6
Child and adolescent psychiatry	38	53	1.3	2.6	16	37	1.9	2.4
General medicine	57	19	2.8	3.2	27	7	4.8	3.6
General surgery	34	3	4.3	4.2	18	0	9.1	4.2
Anaesthetics	128	34	1.4	2.8	80	1	2.6	2.8
All specialties	960	31	1.8	2.9	542	15	2.8	2.9

Source: DHSS Analysis of Returns of Advertised Posts in 1978–79 (published in *Health Trends*).

d. *Mental handicap*

Thirty-two per cent of consultant posts and 48 per cent of senior registrar posts are not permanently filled and many senior house officers and registrars in mental handicap hospitals are in effect not occupying 'training' posts. To provide one whole-time equivalent consultant per 200,000 would require 250 full-time equivalents—in 1980 there were 149. Thus, all grades require expansion.

e. *Psychiatry of old age*

The College's immediate aim of one wte per 200,000 would imply an average of 30,000 people over 65, and the section for old age psychiatry considers that this is inadequate. The section considers that one wte per 25,000 over 65 is desirable. As the elderly population will increase to the end of the century, consultant numbers will require expansion: there are now only six senior registrar posts occupied more than half time in the psychiatry of old age, but two to three posts will be needed in each region to train enough senior registrars to fill the postulated number of consultant posts. (The Medical Manpower Steering Group (GB, DHSS, 1980b) reports that although on 1977-based projections there will be an increase in the number of over 65s of only 1.8 per cent this century, the 85 plus

Table 14 Royal College of Psychiatrist's proposals for consultant staffing levels

	No of sessions per week per 200,000 population	
Special interest	*Immediate needs*	*Long-term goals*
Forensic psychiatry	2	5
Psychotherapy	5	11
Drug-dependency	1	1
Alcohol-dependency	3	3
Old age	11	17
General psychiatry	33	51
All psychiatry[1]	55	88
All psychiatry[1] wte	5	8
1 wte/population of	1/40,000	1/25,000

1 Excluding child psychiatry and mental handicap.

group—of which 20 per cent are demented—will increase by 63 per cent. The Steering Group favours consultants specialising in the elderly rather than general psychiatrists taking a special interest, and supports the College's long-term target of 1.5 wte consultants per district.)

f. *Dependencies*

As most of the College and DHSS proposed sessions will be provided by general consultants with a special interest, the need is for education of general psychiatrists in the fields of drug and alcohol problems rather than for the creation of more posts.

4 General psychiatry

The marked increase in the 1970s of registrar posts has been filled mainly by overseas graduates: this applies to a lesser extent to the SHO grades. The Royal College norms imply the need for a further 330 consultants: in view of the proportion of unfilled posts, it seems uncertain where the doctors will come from to fill these gaps.

The report of the Medical Manpower Steering Group (GB, DHSS, 1980c) aims to help in predicting medical manpower requirements in adult mental illness, forensic psychiatry and psychotherapy over the next 20 years. It acknowledges how difficult it is to define mental illness and acknowledges the changing perceptions of the tasks of psychiatry, and considers that a greater volume of work has been generated by the progressive failure recently of local authorities to provide adequate facilities; other complicating factors have been the revolving-door policy, the population increases (1.3 million between 1968 and 2001) and the more frequent ward referrals to psychiatrists in the district general hospitals. The DHSS also confirmed that the 34 new consultant posts for 1980–81 were to be distributed preferentially in the understaffed regions if there were more bids than posts allowed. It is also considered by the DHSS that there are sufficient registrars and senior registrars to meet future demands. No new posts at these levels are being created. The Central Manpower Committee did suggest informally that any regional shortages at these levels can be solved by a 'redistribution exercise', although such an exercise proved easier in theory than in practice. Finally, it is admitted that the slow rise recently in the number of consultant posts means that the norm of five wte per 200,000 may not be reached by the mid-eighties.

5 The Short report and manpower

The fourth report of the House of Commons Social Services Committee, (GB, Parliament, House of Commons, 1981) chaired by Mrs Renee Short, considered medical education but with 'special reference to the numbers of doctors and the career structure in hospitals'. The recommendations were laid before the House of Commons in 1981 and the majority of them were accepted by the government in a white paper published in February 1982. The government announced its intention of seeking early discussion with the responsible bodies to promote action.

The government intends to increase the number of consultant posts so that a much higher proportion of patient care will be provided by fully trained medical staff; at the same time the number of training posts will be limited to that required to meet future consultant vacancies. The proposal for a two-tier consultant grade or more sub-consultants was rejected, although associate specialist posts should continue to be available to those doctors wishing to apply for them, but only on an individual basis.

The DHSS has suggested targets for doubling the number of consultants over the next 15 years with a reversal of the present ratio of one consultant to 1.8 junior staff to a ratio of 1.8 consultants to one junior over the same period.

On 30 September 1981 there were 1,211 consultant posts in adult mental illness, although 109 of these were vacant. They provided 2.27 whole-time equivalents for 100,000 population; about one for 41,000 population. The College's long-term aim (Royal College of Psychiatrists, 1977) is one whole-time equivalent for a population of 25,000.

If the present complement of psychiatric posts were to be doubled

Table 15

	Consultant establishment in wte at 30/9/81	*wte vacant*	*Service provided*	*College's target*	*Effect of doubling consultant establishment*
Mental illness (adult)	1118	101	1/44,000	1/25,000	1/22,000
Child and adolescent psychiatry	329	51	1/150,000	1/133,000	1/75,000
Psychotherapy	53	5	1/930,000	1/200,000	1/460,000
Forensic psychiatry	19	5	1/2,600,000	1/400,000	1/1,300,000
Mental handicap	189	36	1/261,000	1/200,000	1/130,000

then the long-term aims of both the College and DHSS (of one wte for a population of 22,000) would be exceeded. It can be seen from Table 15 (opposite) that doubling the number of consultant posts and filling them would still leave the specialties of psychotherapy and forensic psychiatry below target but mental illness (adult), child and adolescent psychiatry, and mental handicap, would overtake the Royal College's stated targets.

The second, and linked recommendation is a decrease in the number of junior doctors in most hospitals and in most specialties. However, in psychiatry if the numbers of consultant posts were to be doubled to 3,330 then with a ratio of 1.8 consultants to one junior staff this would result in a modest reduction of junior staff numbers from 2,068 to 1,800; indeed, if the trainee general practitioners who were in psychiatric posts were not to be counted in the first figure the drop in numbers would be very small.

It is the view of the Royal College of Psychiatrists that none of the psychiatric specialties has sufficient senior registrars in training to supply adequately trained doctors for a doubled consultant establishment over 15 years. The number of senior registrars on the career ladder should be about 1/5th to 1/6th of numbers in the consultant grade. Specialties are considered in Table 16 (below).

There would appear to be barely enough senior registrars with three years training in the grade to replace consultants retiring at 60 years plus and fill existing vacancies. Expansion and retirement at 55–60 years would draw on senior registrars who had only been in the grade for two years and who were inadequately trained for promotion. This also applies to child and adolescent psychiatry.

It would seem then that the proportion of senior registrar posts would need to be raised if there were to be any hope of the consultant target being achieved. Many of the new senior registrar posts would be established for a limited period only.

If the numbers of senior registrars were to be increased then the number of registrars would need to be reduced with the aim that a

Table 16

	Present ratio-Consultants: Senior registrars		*Expanded consultant pool*
Mental illness (adult)	1,102:300 11 vacant	enough for	1,500–1,800
Child and adolescent psychiatry	312:84 10 vacant	enough for	420–504

trainee satisfactorily completing training at that level should have a reasonable chance of obtaining a senior registrar post. The proposed ratio is 1:1 with a factor of 10–15 per cent of registrars on top to allow for wastage.

At present there is an excess of registrars—730—and only 300 senior registrars. There would be scope for abolishing some of those registrar posts which do not provide satisfactory training for the MRCPsych and thus progress towards a consultancy, and which in fact exist to meet service needs of patients in settings where these should be met by appropriately constituted teams of consultants, associate specialists, clinical assistants and hospital practitioners.

Registrar posts in the specialties, 135 at present, other than mental illness (adult) should come into rotations if they are not already in them so that more trainees can be offered exposure to psychiatric specialties.

The Royal College of Psychiatrists has made an official reply to the Short committee proposals and the government response to them; although supporting the move towards an increase in consultant establishment, the College considers that this could not be achieved as rapidly as envisaged, certainly not without lowering standards.

The Royal College has broadly accepted that there shall not be sub-consultants or a two-tier consultant grade, but has expressed reservations about doctor substitution. It has also expressed strong reservations about the proposal that academic departments should be subject to the same manpower controls as any NHS posts, pointing out that there would be a serious danger of stifling research initiative if academic departments were not allowed some latitude in making research appointments. The College has also stressed that psychiatry is different from the popular specialties in having a smaller proportion of honorary posts and consequently there is less risk of distortion of the career structure from this source.

The Royal College supports the appointment of clinical assistants and associate specialists on a personal basis and in practice many associate specialists have completed appropriate training and moved to consultant posts. The Royal College does not oppose the appointment of hospital practitioners to the psychiatric service, but is not convinced that this will produce a substantial component.

The Royal College has expressed further reservations about the proposal to have wider experimentation in doctor substitution and multidisciplinary teams, particularly in the 'caring specialties'. Some work in psychiatric services can be carried out appropriately by other professionals but demands additional input from nurses, social workers, psychologists and occupational therapists which should not derive from unsatisfactory medical manpower levels or unsuitable

medical appointments. Multidisciplinary teams have provided inadequate service to patients in some situations and the government's ready acceptance of the concept has given rise to anxiety amongst psychiatrists.

The Short report recommendation that the present target figures (4,080 per year in Great Britain for medical school intake) should not be altered at present is linked to the statement that 'steps must be taken to rectify the career imbalance if unemployment amongst doctors is not to become a problem. It is to be hoped that adjustment of imbalance in the "popular specialties" will allow a better chance of recruitment to specialties such as psychiatry'.

The information above is largely based on Dr Fiona Caldicott's article (1982) 'The Short Report and its Implications' and the Royal College's response to the government's proposal for implementing the Short report.

6 Is present planning adequate or do psychiatrists need to make additional interventions?

a. *The pool of potential recruits*

Neither the Goodenough report (GB, MoH and DoH for Scotland, 1944) nor the Willink report (GB, MoH and DoH for Scotland, 1957) were able to predict accurately over more than the ten years following. The influx of Commonwealth doctors was not anticipated, nor was the rising birthrate, and Willink assumed that the expansion of specialist services would slow down in 1965. Medical school intake, which had steadily contracted with fears in the early fifties of overproduction of doctors, rose as a result of the Royal Commission on Medical Education report (1968). Medical school intake is approximately 3,875 with a target figure of 4,080 places to be achieved in the mid-1980s.

Fears have been expressed of serious medical unemployment within the decade. If this occurs, an increasing number of British trained doctors will probably enter psychiatry, attracted by the better promotion prospects. Unfortunately, although this may improve the manpower figures these doctors might not raise the standard of psychiatry practised in this country, as they may be those who have fallen off the promotional ladder or given up at the first rung of the ladder of other specialties, with little enthusiasm for psychiatry which they adopt as a second choice. This questions how much quality should be sacrificed to quantity in efforts to achieve manpower targets.

The pool of potential recruits may well be increased further by the

Table 17 Consultant and senior registrar posts not permanently filled (percentages)

% wte	*Consultant posts vacant*[1]	*Consultant posts occupied by locum*[2]	*Consultant posts not permanently filled*[3]	*SR posts vacant*[1]	*SR posts occupied by locum*[2]	*SR posts not permanently filled*[3]
	%	%	%	%	%	%
Mental illness	8	3	11	8	2	10
Mental handicap	24	8	32	42	6	48
Child and adolescent psychiatry	18	3	21	16	5	21
Forensic psychiatry	9	2	11	22	0	22
Psychotherapy	16	3	19	6	0	6
All psychiatry	12	3	15	13	3	16
All specialties	8	2	10	9	2	11

1 *Vacant posts* × *100*. Vacant posts + permanent paid staff in post (honorary staff are excluded from analysis). 'Vacant posts' = established and approved paid posts not occupied by a permanent holder at 30/9/80. Post which had been neither occupied nor advertised are included (for the first time, so that direct comparison with previous years is not possible).

2 *Locums in post* × *100*. Vacant posts + permanent paid staff in post. 'Locums in post' = wte of posts wholly occupied by locums and wte occupied of posts partly occupied by locums.

3 % vacant + % occupied by locum. Locums in temporary posts, or acting in the temporary absence of a permanent holder, are excluded.

Source: DHSS Manpower Tables as of 30/9/80.

mandatory vocational training in general practice, and the introduction of a multi-vocational, more generic pattern of general professional training: more trainees will experience psychiatry and a proportion will remain in the field. However, as the Royal College has pointed out, (1979) GPs trained in psychiatry may take on the treatment of more cases themselves, but with increased awareness of psychiatric problems they may also refer more cases to the psychiatrists.

b. *Career prospects*

Table 17 (opposite) shows that across virtually the whole psychiatric field there are vacant or locum-filled senior posts, and Tables 18a and 18b (pages 170 and 172) demonstrate how little competition there is for senior posts in psychiatry, measured on various indices.

Medical students, however, do not base their choice of career on such figures and indeed only about one in three have made a firm choice of career by the pre-registration stage (Parkhouse, 1980; Hutt and others, 1981) and only half the remainder within the next five years. A retrospective survey of 6,561 doctors who had qualified from two to twenty years earlier also showed that only a quarter of those who changed specialty did so because of career prospects or job competition. The majority of the doctors thought that job security, fitting in with family circumstances, and good buildings had been amongst the factors important in making their choice of career. Only a third thought that the status of the specialty within the profession has been important in their choice and only 11 per cent of the men (41 per cent of the women) considered regular working hours to have been of great importance in their choice (about half the women also thought that the availability of part-time posts was of great importance). Long diagnostic investigations and social problems (features of psychiatric practice) were found attractive by less than one-third of the consultants—but less than a quarter of them found attractive using complex apparatus, laboratory work, and unpredictable or irregular hours, all factors which feature less in psychiatric work (77 per cent of junior psychiatrists are contracted for less than 80 hours a week, a higher proportion than in any other specialty).

Turning to psychiatrists, a survey of consultants in general psychiatry (Brook, 1981b) showed that a positive interest in the work had been most important in making the decision to enter psychiatry, followed by fitting in with family circumstances, geographical location and availability of senior posts. The women felt that the availability of part-time and junior posts was also important. A quarter of the consultants had qualified overseas but only half of these

Table 18a

Consultant appointments	*No of posts*			*Successful candidates*						
	Total analysed	*Total unfilled*	*Candi-dates per post*	*% Female*	*% Overseas graduates*	*C*	*SR NHS paid*	*Other*	*Years as SR (mean)*	*Age if first C appoint-ment (mean)*
Anaesthetics	128	43	1.4	23.5	16.5	12	60	13	2.8	34.8
General medicine	57	11	2.8	4.3	4.3	2	27	17	3.2	34.0
General surgery	34	1	4.3	0	0	2	24	7	4.2	36.8
Geriatric medicine	39	13	1.9	15.4	30.8	4	18	4	2.1	37.5
Gynaecology and obstetrics	29	4	3.2	12.0	4.0	3	16	6	3.4	37.3
Haematology	31	10	1.4	23.8	9.5	4	11	6	3.1	33.4
Histopathology	44	18	1.2	19.2	23.1	4	10	12	3.5	34.9
Opthalmology	23	4	1.7	10.5	15.8	3	13	3	3.0	38.1
Paediatrics	37	7	2.1	26.7	3.3	3	15	12	2.7	35.2
Radiology	91	35	1.1	21.4	35.7	8	36	12	2.7	36.2
Traumatic and orthopaedic surgery	41	5	2.0	0	5.6	3	31	2	3.5	35.6
Mental handicap	47	36	0.6	18.2	27.3	5	4	2	2.0	35.0
Mental illness (adult)	107	37	1.5	25.7	30.0	14	33	23	2.1	36.8
Child and adolescent psychiatry	38	20	1.3	44.4	16.7	5	10	3	2.6	35.0
All hospital specialties	950	294	1.8	17.0	17.7	96	403	167	2.9	25.8

had wanted psychiatry as a first choice, compared with three-quarters of the home graduates. Many consultants felt they had had insufficient experience in the sub-specialties to make an informed choice about a career in these fields.

c. *Effects of remuneration*

With the likely prospect, in the short term at least, of increasing numbers of newly qualified doctors and increasing numbers of frozen posts, the overall level of remuneration is unlikely to affect recruitment to psychiatry. However, two controversial issues may have implications for manpower in psychiatry, depending on political developments both outside and within the medical profession.

i. *Merit awards*

Traditionally psychiatry has received a relatively small proportion of such payments (Tables 18a and 18b, opposite and page 172). In 1979, consultants within the psychiatric field represented 11.5 per cent of those eligible for the awards, but only 8.2 per cent of recipients. More strikingly, whereas 13.3 per cent of all consultants received the substantial A+, A or B awards, these went to only 4 per cent of child psychiatrists, 5.9 per cent of forensic psychiatrists, 6 per cent of consultants in mental handicap, 8 per cent of adult psychiatrists and 9.6 per cent of psychotherapists (Table 19, page 174). In 1979 a survey of 6,561 doctors showed that 16 per cent considered that the frequency of merit awards was of great importance or of some importance in making their career choice. The overall effect on recruitment to psychiatry may be negligible and it may be offset to some degree by the provisions for earlier retirement and better pension rights conferred by mental health officer status in recognition of the nature of psychiatric practice.

ii. *Private practice*

The number of subscribers to private health care schemes in 1981 had risen to 1,715,000 and 6.7 per cent of the United Kingdom's population was covered. The effect must be to increase the demand for private psychiatric treatment, especially as more private psychiatric beds are now available.

Until recently, most private psychiatric practice was confined to psychoanalysts working entirely privately, and to a small number of consultant psychotherapists working part-time in the NHS. In addition a number of maximum part-time consultants have private consulting rooms, especially in the London area, while a few psychiatrists work full-time in private psychiatric hospitals.

This is not the place to argue the merits of private practice but it would appear to be essential to recognise that the effects on

Table 18b

Consultant appointments	*No of posts*					*Successful candidates*				
						Preceding grade				
	Total analysed	*Total unfilled*	*Candi-dates per post*	*% Female*	*% Overseas graduates*	*C*	*SR NHS paid*	*Other*	*Years as SR (mean)*	*Age if first C appoint-ment (mean)*
Anaesthetics	80	1	2.6	20.3	19.0	4	56	19	2.8	30.9
General medicine	27	2	4.8	4	12.0	1	8	16	3.6	30.9
General surgery	18	0	9.1	0	5.6	1	6	11	4.2	32.1
Geriatric medicine	36	14	1.8	9.1	63.6	1	18	3	3.2	34.0
Gynaecology and obstetrics	8	0	10.6	0	0	0	7	1	2.5	32.1
Haematology	18	1	2.6	52.9	35.3	0	14	3	2.0	29.8
Histopathology	22	6	1.5	25.0	25.0	0	11	5	2.4	30.1
Opthalmology	11	2	2.2	0	22.2	1	7	1	2.8	33.4
Paediatrics	13	1	3.0	0	0	0	10	2	2.9	30.7
Radiology	60	19	1.4	22.0	34.1	3	35	3	2.7	31.5
Traumatic and orthopaedic surgery	27	0	5.4	0	11.1	1	20	6	3.7	32.6
Mental handicap	16	8	0.9	12.5	62.5	0	6	2	2.6	36.9
Mental illness (adult)	57	6	2.1	27.5	41.2	2	36	13	3.0	32.1
Child and adolescent psychiatry	16	6	1.9	10.0	30.0	1	8	1	2.4	34.7
All hospital specialties	542	84	2.8	15.9	26.4	26	317	115	2.9	32.1

psychiatric manpower of the expansion of private practice may encourage graduates to enter psychiatry, but this would have to be offset by the potential loss of experienced clinicians from the NHS and academic departments. Furthermore, the possible development of a service limited increasingly to the severely disadvantaged members of the population, while the more acute and 'treatable' cases go to the private sector, should cause grave concern not least for its effects on recruitment.

d. *How can future requirements be calculated?*

The Royal Commission (1968), estimated that the number of doctors would continue to increase at 1.5 per cent per year. The DHSS in 1979 concluded that it was still reasonable to accept the Royal Commission's estimate, taking a number of factors into account. These included demographic factors, allowing for not only estimates of the total population, but also changes in the age-structure and therefore of the medical demands of the population. Availability of economic resources based on predictions of the GNP was taken into account, though both this and population figures are notoriously difficult to ascertain correctly.

Is the present rate of recruitment from medical schools into psychiatry sufficient to man services at the present level and to allow for the recommended growth? Parkhouse in 1979 and 1980 described the percentage of medical students naming psychiatry as their first career of choice, as 4 per cent and 2.9 per cent respectively (Parkhouse 1980; Parkhouse and others, 1981). Assuming that this number carry through their choice, and with the intake of medical students rising to 4,000 by 1985, this could mean that between 160 and 116 doctors will start training each year in the specialty. This number is theoretically sufficient to maintain a pool of 1,500 consultants (approximately the number required if the Royal College norms are achieved) and in addition to allow for a further expansion of about 5 per cent per annum. The rough and ready calculations behind this estimate assume:

i. That all those choosing psychiatry will stay in the specialty.

ii. That all consultants work full-time and for a period of 25 years, though the discussion so far has taken no account of the future balance between medical and non-professional personnel, or the changing role of the consultant.

Table 19 Health Trends 1981—distinction award holders in England and Wales at 31 December 1979

Specialty	*Eligible practitioners*		*Award holders*										*Non-award holders*		*Award holders in speciality as % of all award holders*
			All		*A+*		*A*		*B*		*C*				
	No	*%*	*No*	*%*	*No*	*%*	*No*	*%*	*No*	*%*	*No*	*%*	*No*	*%*	*%*
Accident and emergency	128	0.9	10	7.8	—	—	—	—	1	0.8	9	7.0	118	92.2	0.2
Anaesthetics	1,605	11.6	438	27.3	9	0.6	30	1.9	87	5.4	312	19.4	1,167	72.7	9.2
General medicine	1,028	7.4	473	46.0	21	2.0	61	5.9	121	11.8	270	26.3	555	54.0	10.0
General surgery	956	6.9	465	43.6	15	1.6	51	5.3	129	13.5	270	28.2	491	51.4	9.8
Geriatric medicine	386	2.8	89	23.1	3	0.8	3	0.8	14	3.6	69	17.9	297	76.9	1.9
Haematology	324	2.3	101	31.2	—	—	10	3.1	33	10.2	53	17.9	223	68.8	2.1
Histopathology	556	4.0	218	39.2	5	0.9	22	4.0	59	10.6	132	23.7	333	60.8	4.6
Obstetrics and gynaecology	705	5.1	260	36.9	7	1.0	22	3.1	74	10.5	157	22.3	445	67.1	5.5
Opthalmology	399	2.9	137	34.3	3	0.8	11	2.8	35	8.8	88	22.1	262	65.7	2.9
Radiology	818	5.9	257	31.4	6	0.7	20	2.4	72	8.8	159	19.4	551	63.6	5.4
Traumatic and orthopaedic surgery	639	4.6	215	33.6	2	0.3	14	2.2	55	8.5	144	22.5	424	66.4	4.5
Child and adolescent psychiatry	275	2.0	35	12.7	1	0.4	3	1.1	7	2.5	24	8.7	240	87.3	0.8
Forensic psychiatry	17	0.1	5	29.4	—	—	—	—	1	5.9	4	23.5	17	70.6	0.1
Mental handicap	151	1.1	34	22.5	—	—	2	1.3	7	4.6	25	16.6	117	77.5	0.7
Mental illness	1,035	7.9	304	23.0	11	1.0	20	1.8	67	6.2	206	19.0	781	72.0	6.4
Psychotherapy	52	0.4	10	19.2	—	—	2	3.8	3	5.8	5	9.5	42	80.8	0.2
All medical specialties	13,316	95.4	4,572	34.3	114	0.9	429	3.2	1,221	9.2	2,808	21.1	8,744	65.7	95.4

EMPHASES

16.1 'Norms'

The deteriorating economy and increasing NHS expenditure which only keeps pace with inflation suggest that in spite of the government commitment, the number of new consultant posts suggested by the Short committee to be created over the next few years will not materialise in full. Even if they were created, however, they could not be filled satisfactorily unless the manpower profile in psychiatry is changed, as there are insufficient junior staff adequately trained to fill even the existing consultant posts.

It could be argued that the College norms should be reviewed more frequently in view of the changing workload as a result of, for example:

a. the administrative duties following the 1974 NHS reorganisation and the forthcoming reorganisation;

b. constantly escalating demand by patients for help with personal and social problems;

c. the recent increase in the rates of self-poisoning;

d. the trend towards the teaching of medical students in peripheral psychiatric hospitals;

e. community services demanding more patient contact and more travelling time;

f. shortages of paramedical and supportive staff and cuts in the social services expenditure;

g. the improved general practice training resulting in higher detection rates and possibly higher referral rates;

h. the taking on of counselling and treatment by paramedical staff (for example, psychologists attached to GP surgeries, nurse therapists, and so on) which may reduce the workload but will increase the supervision time required.

If the most recent norms proposed by the Royal College are accepted, (Table 14, page 162) which although rough are at least based on estimated need, more consultant posts must be created in the specialties and more consultants in general psychiatry are needed to take special interest in the fields such as the dependencies, particularly in districts where there are no full-time posts in these specialties and no full-time regional specialists to contribute towards the service.

16.2 **Medical students**

Following from the retrospective studies of career choice, it seems important to find out what medical students themselves feel is influencing their choice of career. There are consistent differences in the proportion choosing psychiatry between various medical schools, but it is not known whether this proportion correlates with other variables, such as the selection criteria of the medical school, or the duration of the period spent in psychiatry. Research into the motivation of medical students for choosing psychiatry should seek answers to the following questions:

a. Why does the proportion choosing psychiatry vary from 0 per cent to 10 per cent depending on the medical school? Despite marked annual variations, there are identifiable trends which distinguish medical schools that appear to encourage students to enter psychiatry.

b. How does the teaching of other clinical subjects influence the choice of psychiatry as a career?

c. Ninety-seven per cent of pre-registration doctors do not put psychiatry as first choice. At what stage and why have they made that decision?

d. Do those choosing psychiatry have different pre-existing attitudes towards mental illness or towards medicine?

16.3 **Psychiatric trainees**

a. As it has been shown that most consultants work where they trained as senior registrars, priority should be given to creating new senior registrar posts in the regions where there are difficulties in filling consultant posts. This said, it should be emphasised that good training for senior registrars must remain the paramount factor in deciding where new posts are created. Proleptic consultant appointments should be considered where appropriate, for example in mental handicap. Senior registrar posts in the less popular areas may also be made more attractive by linking them more closely with local teaching hospital posts (at present, many senior registrars rotate either around the periphery of a teaching hospital or within the teaching hospital posts). With the implementation of the Short report, trainees will be concentrated in few hospitals. Existing registrar/SHO posts in peripheral hospitals should, wherever possible, be linked up with or transferred to rotational training schemes. This is particularly important in the less popular specialties, as it provides experience not otherwise obtained, and may encourage the

trainee to take up the subject later on, either full-time or as a special interest. (It was mentioned earlier that many newly appointed consultants feel that they had insufficient experience of the sub-specialties to make a choice of them as a career.)

To allow for expansion in the numbers of consultants within a relatively short period, more senior registrar posts will be needed, but the numbers should fall again when the stage of expansion has been completed. This conflict can be readily resolved by creating senior registrar posts for a limited period or as 'one holder' jobs.

Different types of senior registrar posts will need to be created in order to allow for the changes in consultants' work. In the field of mental handicap, many posts will combine work in handicap with child psychiatry or with general psychiatry.

It may be that, increasingly, general posts will be described as having 'a special interest': in forensic psychiatry, psychotherapy, alcoholism, the addictions and rehabilitation. An important task for the Joint Committee for Higher Psychiatric Training will be to produce guidelines for training programmes in special interest fields, which will then need to be implemented locally.

Where a senior registrar post has been difficult or impossible to fill, it is necessary to look for the reasons for this.

b. Given an increase in the numbers of senior registrars together with a drop in the total numbers of trainees, the numbers of registrars consequently will need to be reduced. How great a reduction would be needed in the number of senior house officers is problematical, as experience at this level will be sought by trainees in other specialties. It would seem reasonable to assume that the major reduction in numbers will be at registrar level. How is this to be accomplished? One way would be by closing posts and replacing for the service need with new consultant posts.

A survey in the South West Thames Region (Stead and others, 1980) had shown that many doctors had been in the training grade for numerous years, many were not interested in being trained, and some of their consultants did not wish to train them. These doctors were really delivering primary care. Professor Crisp at the conference described this as a corrupt and bankrupt system. It is clear that posts like these should be abolished, either by closing them or redeploying them to centres offering adequate training. Careful thought has to be given to the possibility that reducing the number of registrar posts (and as well the overall period of training) could adversely affect psychiatric specialties by contracting the number of trainees from which they recruit.

c. There are many vacant posts, particularly in mental handicap,

child psychiatry and the psychiatry of old age (GB, DHSS, 1980c), and more consultant psychiatrists are needed to fill these posts. However, the policy of decentralising senior registrar posts raises difficulties in the specialties, since proper training at a senior level can only be given where there is a 'critical mass' of specialists and peers. If this is not available a considerable part of the trainees' time will have to be spent travelling from base to the nearest specialist unit. In some circumstances, in order to provide special training it may be necessary to disregard rigidly applied regional norms.

16.4 **New posts**

It could be argued that the priority now should be to fill the posts already created rather than to create new posts. However, this would be short-sighted because one of the reasons for the failure of many posts to attract applicants is the dauntingly large workload. One of the ways of improving the attractiveness of a post is to create another post which will allow a more reasonable workload, and also prevent working in isolation, which is a feature of some unpopular jobs for consultants. Experiments along these lines have already been carried out successfully in anaesthetics.

16.5 **Quality of posts**

a. Increased efforts should be made in other ways to improve the attractiveness of unfilled consultant posts—this would include the provision of additional resources, paramedical and secretarial staff or improved office/outpatient accommodation, where these appear to be a problem in attracting suitable applicants.

b. The work factors influencing choice of career (as discussed earlier) are presumably assessed by the medical student on the basis of what he sees in the work of those around him. If the workload of these consultants is excessive, the conditions poor and the facilities minimal, this must discourage potential recruits. For this reason if for no other, it is important to improve working conditions, particularly in the undermanned areas, and it is recommended that priority be given to those peripheral hospitals involved in medical student teaching. (Support for this step occurs in the Joint Consultants Committee's evidence to the Social Services Select Committee.)

c. Improvement of working conditions—such as provision of a library, making doctors' dining facilities more attractive, and so on—costs money, and of course whenever an advertised post is filled, a salary needs to be found for the occupant. Funds do not seem to go to those who do not ask for them, and perhaps there needs to be a

local 'spokesman' to investigate the reason for the lack of suitable applicants for certain jobs and to press for improvements in conditions. This relatively independent spokesman would have another function, namely to ensure that the most attractive sections of a particular consultant post are not hived off to the incumbent consultants when the post becomes vacant—a situation which may not be infrequent. This could improve recruitment, both directly by expediting the improvement of conditions witnessed by medical students and by encouraging the filling of advertised posts and so reducing the workload (which, in turn, would improve recruitment to psychiatry) and indirectly by adding to the number of potential teachers of psychiatry. Such a spokesman could perhaps be one of the Royal College assessors on consultant appointment committees, and responsible for a region not his own.

d. Financial inducements for late retirement need consideration. The College's view (Royal College of Psychiatrists, 1977) is that after 1981, there will be an increasing trend for mental health officers to retire at 55 (or with maximum benefit at 58), which would decrease the stock of active doctors.

e. The possibility of NHS consultants being offered sabbatical leave to enable them to study or engage in a research project full-time should be taken up with the DHSS. Increasing their numbers would make it feasible for consultants to have two sessions a week for private study, research or pursuing special interests, at present enjoyed by senior registrars.

f. Recommendations about women and overseas doctors are outlined in Chapters 15 and 14 respectively.

16.6 **Future planning**

Psychiatry's manpower requirements—radically different from the 'popular' medical specialties—need to be presented in an informed way to the Central Manpower Committee. To present an effective argument, the Royal College's Manpower Committee must be in a position to have information—region by region, specialty by specialty, grade by grade—about vacant posts and those that have been empty for a long time.

16.7 **Career guidance**

The Short report has rightly emphasised the need for career guidance. In the medical schools, the academic departments will have a special responsibility—for example by taking part in providing career

guidance and paying special interest to students who have indicated a preference for psychiatry; at the postgraduate stage, this will be an increasingly important part of the clinical tutors' task. Postgraduate deans will also be involved and will look to regional specialty advisers for their assistance.

17 Relations with other specialties and professions

The role of the psychiatrist

One of the requirements in deciding the relationship between psychiatry and related professions is the definition of what it is exactly that psychiatrists do. Consideration can be given first to the patients they treat. A large proportion of patients do not fall convincingly into any clinically unitary diagnostic category, but often have combinations of illness, personality disorder, social problems and relationship disorder. A psychiatrist, even when he defines the limits of his expertise extremely narrowly, is unlikely to avoid seeing referrals he may come to view as inappropriate. Another approach is to focus on the field of expertise of the psychiatrist: disputes and problems arise in relating to other professions in part because of the complexities involved when psychiatrists attempt to delineate their areas of competence (Shepherd, 1982).

Some of the problems which psychiatrists have in terms of their professional identity have been documented (Jones, 1978). The various roles of psychiatrists can be differentiated as doctors, administrators, agents of social control, and innovators. It might have been possible in the past to see psychiatry and general medicine as parallel and interacting spheres of work, of equal scope and importance; for the most part psychiatry has now become a specialty within general medicine, Jones suggests, and proposes further that the restriction of psychiatry to the field of general medicine may gain for psychiatry the prestige which still attaches to general medicine in the eyes of the general public. Other problems arise from there not being any unitary body of theory on which the practice of psychiatry is based. Another complex aspect in defining the psychiatrist's work is related professional restrictiveness, when much of the psychiatrist's work gets done in psychiatric hospitals or units which other physicians rarely enter.

Any profession has to carry conviction that its services in the society are essential for the public well-being, and to convey clearly those features which its members have in common. A profession will often experience a dual pull, to the centre for unity and to the periphery for growth. The periphery of psychiatry inevitably constitutes a blurred area where ambiguous boundary markers have to be adopted, and the penumbra of the professional territory seems to be available for contest by psychologists, social workers, voluntary groups, or others who may seek to colonise it. Gwynne-Jones (1982)

has argued that a psychiatrist should have one foot in medicine, and one in the social sciences, and should be prepared to work at the interface where the psyche meets the soma, and to accept the multiple roles which follow, and which society requires.

Along similar lines it has been suggested that: 'if the doctor is not something of a creative artist—as well as something of a social worker, priest, psychotherapist, teacher, and friend—he may well do harm no matter how technically competent he is at diagnosis' (Wing, 1978). A doctor may equally well do harm by trying to take on too many roles; there is an important need for the doctor to recognise the limits of his ability.

Problems can also be caused by overlapping areas of competence. All professional health workers naturally tend to value the uniqueness of their own contribution. How much of a doctor's work could be undertaken by nurses, and how much of a nurse's work by nursing assistants? What are the essential differences between a psychiatrist and a clinical psychologist? Can a health visitor undertake most of the social worker's work so far as general practice is concerned?

Each of the health professions tends to consider that the essential skills of the other professions could be acquired within a relatively brief time (Wing, 1978). It is against this complex background that the challenges facing psychiatrists in relating to other disciplines must be considered.

Limits to psychiatric practice

In the United States in the early 1960s the era of specialisation was in full swing, private practice was pre-eminent and lucrative, and the importance of psychoanalytic theory in psychiatry was widely endorsed. The standing of specialisation, private practice and psychoanalysis came under renewed scrutiny; and the numbers of recruits to psychiatry declined (Taintor and Neilsen, 1981).

Even at the height of the boom in psychiatry in the United States, there was some awareness that psychiatric care calls for more extensive contributions than can be provided by psychiatrists alone, a view which was clearly anticipated 75 years ago by Emil Kraepelin (1962): 'Clinical observation must be supplemented by thorough examination of healthy and diseased brains, neurology, the study of heredity and degenerative diseases, the chemistry of metabolism and serology'.

The assertion makes it apparent that Kraepelin had in mind the need to draw on a group of primarily biological sciences and on the clinical discipline of neurology. This applied when the patients regarded as falling within the province of the psychiatrists were

largely confined to those in custodial care and suffering from a relatively restricted range of conditions; in terms of the disorders included in Section V dealing with mental disorders in the International Classification of Diseases (ICD) this would comprise no more than the organic and functional psychoses, the most severe neurotic disorders, and the more profound grades of mental subnormality.

Since then three major changes have come about. First, the spectrum of psychiatric disorders has been widened considerably as the psychiatrist's institutional role has come to be regarded as no more than one aspect of his work, and perhaps not the most important of his activities. Personality disorders, the psychosocial aspects of physical disease, and a whole range of what ICD 9 calls 'symptoms and other ill-defined conditions'—to take just three examples—have long since extended the boundaries of Section V.

Second, it has now been shown that most of those who present with these disorders do so not merely to psychiatrists or neurologists, but to a variety of other specialties and professions, both medical and otherwise, including general physicians, general practitioners, social workers, nurses, and clinical psychologists, and also non-professionals and indigenous healers.

Third, it has become increasingly apparent that the range of related sciences must be expanded to represent the psychological and social fields of inquiry, as well as the biological, if mental disorders are to be adequately investigated and treated. A quantitative index of the situation emerged from a survey carried out in 1980 of graduates in British medical research (Sadler and others, 1981).

Table 20 (page 184) gives some of the findings from that survey which gathered data on the numbers, distribution and characteristics of graduates engaged largely or wholly in clinically oriented and basic biomedical research in 906 institutions which included all university departments in medical faculties, and in science faculties related to medicine in the United Kingdom. A marked preponderance of non-medical graduates was found in the field of psychiatric research when compared with the position in other major clinical disciplines. The survey included departments of psychology but did not include a number of departments where there may have been interest in mental disorder (for example, social sciences).

These potential allies in the field of mental disorder do not see themselves as helpmates so much as partners, and even senior partners, in a joint enterprise. Psychiatrists have had to justify some of their claims to unique expertise as the question of inter-professional relationships has come increasingly to the fore. In the case of non-medical collaborators, and most particularly psychologists, this development has been exceptionally prominent in the

United States where the 'death' of psychiatry had been widely forecast (Torrey, 1974), and an American Board of Psychiatric Medicine has been founded to ensure that professional rights are safeguarded. The debate on this issue is generating considerable heat, as the following combative statement indicates (Mathis, 1981): 'There is probably no single simplified answer as to why students find psychiatric medicine unattractive, but some of us feel strongly that the over-exposure to non-physicians in the departments of psychiatry is a major factor . . . This department does not, and will not, have full-time faculty [that is, teaching staff] who are not psychiatrists . . . We hope that we can demonstrate that our department of psychiatric medicine, composed as it is and will be only of psychiatrists, will present to the student a role model and a type of medical practice that is attractive to them' (sic).

Psychiatry and psychology

Some American clinical psychologists have proceeded in turn to develop their own autonomous activity in a form they have called 'behavioural medicine'. Such fragmentation of health services is clearly not in the interests of good health care. Compromises in attaining satisfactory ways of working together need to be sought. Many medical specialties require that the doctor, after or as a continuation of his general and advanced medical training, also becomes proficient in a particular field of study basic to that specialty. An epidemiologist may also need to become expert in endocrinology, immunology, bacteriology, or some other relevant biological field. A psychiatrist, likewise, is not rooted in a single discipline; at the least, he needs to be both a physican and a psychologist. His concern is

Table 20 Graduates engaged in medical research areas in Britain

	Number of non-medical graduates	*Number of medical graduates*
Medicine	560	467
Surgery	136	210
Neurology and neurosurgery	38	53
Community medicine	187	121
Mental health and psychiatry	398	124
Psychology	192	7

psychopathology and the changes, natural or induced, occurring with mental disorder. An understanding of psychopathology requires parallel understanding of normal psychology. Psychology is a major basic science of psychiatry and a superficial or partial knowledge is insufficient.

It could be argued that a psychiatrist needs to remain constantly aware of the ongoing developments in psychology, in addition to what is now widely accepted as obligatory in postgraduate psychiatric curricula, and provision should be made for update courses during psychiatric practice. If trained along such lines, psychiatrists may be seen not only as consultants in psychological medicine, but also as applied psychologists of a particular type.

When a psychiatrist is seen as both physician and psychologist, there is inevitably an overlap apparent in the behaviour and functions of psychiatrists and psychologists. One sector will be the relatively exclusive area of the psychiatrist (for example, pharmacological treatments); another sector will be the area of the psychologist (for example, certain assessment and psychometric procedures); there will then be an area of activity common to both disciplines, typified by the psychological treatments in which an observer might differentiate no professional differences of practice. Such a complete identity of behaviour has been claimed in the field of psychotherapy, in which major unresolved questions of process and outcome need to be further explored. With such overlap some degree of conflict stemming from vested interests is inevitable, especially as there is encroachment as well from each side into the less disputed territories of the other.

The suggestion has been made that psychiatry can well be divided into two independent parts, one concerned with organic disorders and their treatment, largely medical in nature, the other concerned with behavioural disorders and their treatment. The former discipline has been advocated by Eysenck (1975) as the prerogative of medically trained psychiatrists. This claim, needless to say, has been accorded scant acceptance. Within psychology itself there has been a reaction against behaviourism in practice and theory, and there has been a certain advocacy of some of the 'humanistic' therapies. Evidence of such a reaction can be seen in the founding in 1973 of the Psychology and Psychotherapy Association as a multidisciplinary organisation open to members of the helping professions whose object is to explore and specify the implications of making the 'person' central to psychological enquiry, the emphasis being on psychotherapeutic practice and on teaching in both psychology and psychological therapies.

Clinical psychologists themselves, in defining their own areas of

particular competence, may be drawn to practise many non-physical therapies. Future divisive competition can be avoided only by mutual respect based on recognition of particular disciplinary contributions.

Psychiatry and social work

The elements of 'overlap' and 'conflict' evident with psychology are apparent as well with social work.

Social workers also apply a variety of techniques closely related to those used by doctors and psychiatrists. Social casework has come to be based on the two disciplines of sociology and psychology. Social workers, in general, thus provide not only practical help and services, but practise a number of interventions such as counselling, behaviour and family therapy, and group psychotherapy in order to ameliorate their clients' emotional and relationship problems. These techniques are adapted from those used in other professions such as clinical psychology, psychiatry and psychoanalysis.

Many social workers consider that doctors undervalue their professional role and have little knowledge of the social work task. Doctors are often accused of treating social workers as 'handmaidens' expecting them to carry out an instruction given to them rather than treating them as 'equal professionals'. Doctors in turn may have found social workers difficult to work with, and have considered that social workers have insufficient knowledge of medical responsibilities.

Social workers have come in for much criticism in recent years, and have received much adverse publicity when their decisions may have been seen in retrospect to have been wrong. They are perhaps an easy prey for criticism in as much as the aims of social work have never been very clearly defined and the profession may attract some people who see their task as putting the world to rights, rather than giving practical help where it is needed and would be effective. Counselling and casework have been seen as the essence of social work, and yet there has been little evaluation of its effectiveness, and some work has suggested that social work intervention in certain circumstances can be harmful.

Most psychiatrists would argue that social workers play an invaluable part in the multidisciplinary team; that all too often they get left with the rather intractable, practical problems remaining when others have achieved what they can by means of pharmacotherapy or psychotherapy. Unfairly they may have the difficult domain of the personality disorders assigned to them when psychiatrists neglect this aspect of their specialty. There is an urgent need for the stronger recognition of the particular professional skills of psychiatric social workers, and their crucial importance in psychiatric practice.

Psychiatry and nursing

It has been established and is now unquestioned that psychiatric nurses can work independently and outside the institutional setting. More important, however, has been the widening in scope even of community nursing practice from a narrow perspective of after-care for those who have spent a period in an institution, to that of actually minimising the need for admission for inpatient care, and in some settings of positive moves to mental health education. This wider role has led to the need to extend the time-honoured alliances between psychiatrists and psychiatric nurses.

On a professional level, the community psychiatric nurse must now liaise with health visitors, district nurses, school nurses, and general practice nurses, while also working closely with general practitioners, medical specialists, and a whole variety of other professional groups (for example, teachers), some of whom have no formal relationships in the provision of institutional care. The overlap with social work also takes on a new significance.

A movement has thus begun whereby nursing skills are being developed to an extent which could lead to a major overlap with practices hitherto seen as being the domain of the medical practitioner. Some critics of these developments have sought to argue that the nurse-practitioners so constituted are no longer nurses, but form the basis of new professions.

The Royal College of Nursing is satisfied, however, that the knowledge base and the skills utilised are grounded in nurse training (Commission on Nursing Education, 1985). Major impediments to these developments could come from changes in basic nurse training towards a physical illness oriented 'comprehensive' training.

These and indeed many other reasons make it important that 'psychiatry' identifies its own areas of responsibility and the functions inherent in fulfilling those responsibilities. Psychiatric nursing has moved from a limited theoretical base combined with practical experience related in a high degree to physical care, to a more academically demanding preparation, with much greater emphasis on theory and practice and the development of social and psychological skills. This change must continue and will require support from other mental illness professions. Equally, other disciplines must recognise the contribution of nursing in providing improved services, and incorporate understanding of this aspect of nursing in their own professional education.

Psychiatry and general practice

In the sphere of general practice, another dimension is derived from the epidemiological fact that the great bulk of mental illness is identified and managed by the primary care doctor; moreover, his training and experience often equip him insufficiently to provide the expert intervention needed by patients with disturbances of mental health. The term 'psychiatry' does not appear in the index of a recent textbook for teachers of general practice (Cormack and others, 1981). The potential cooperation between general practitioners and psychiatrists is extensive and eminently beneficial (Clare and Lader, 1982).

The practical consideration is that all psychiatrists who aim to coordinate the fields of general practice and their own specialty should receive adequate training in the primary care setting. Six months' training setting in a teaching practice has been strongly advocated, when access to other members of the primary care team can be experienced. Subsequent working in primary care is bound to be a continuing learning experience for the psychiatrist as much as for other workers. The implication here is plainly that the psychiatrist must be regarded as a student as well as a teacher in the primary care setting.

Psychiatry and other disciplines

The relation of psychiatry to other clinical disciplines is complicated by the extended definition of the range of mental disorders. The psychiatrist has been compelled to recognise that psychiatric care is not only provided by psychiatrists, as might have been assumed 25 years ago. It is now accepted that psychiatric disorder is dealt with by numerous professions, as well as by people who make no claim to any profession at all.

To many practitioners of medicine, the contribution of the psychiatrist has been viewed as little more than the application of a commonsense psychology and, accordingly, the claim for independent status of the discipline has often been called into question on this uninformed score. In recent years, it has been argued, generalists have tended to become more psychiatrically oriented and more equipped with psychiatric knowledge and skills; on the other hand, psychiatrists have tended to be less familiar with and experienced in the somatic disorders. There are probably good grounds, therefore, for the attachment of general physicians to psychiatric units and hospitals.

Other disciplines which also have the closest relations with psychiatry include physiotherapy and occupational therapy, not

specifically considered here in detail. The former may have a role to play in such treatments as relaxation techniques, while the latter already have a vital function in inpatient programmes, and in the assessment of a patient's practical abilities in psychogeriatric care in rehabilitation programmes.

Implications for recruitment

Numbers in themselves do not constitute a yardstick for the recruitment problem in psychiatry. The broader delineation of mental illness has charted a much larger territory than was originally defined, but it does not necessarily follow that it should be serviced exclusively by an increased number of specialist psychiatrists. Mental health care depends on the development of several specific disciplines and collaboration among several professional groups. For his part in the implementation of this task the psychiatrist must now define his own contribution and his own function if his role and status are to be justified. To hold its own in the face of scientific advances on the one hand, and the rival claims of other groups of the helping professions on the other, psychiatry now depends on recruitment characterised by quality rather than quantity. If this is not achieved, the specialty must inevitably decline to become a dominantly administrative one, a change which also threatens the field of mental subnormality to which geneticists, psychologists, chemists, paediatricians, and educationalists, among others, already contribute.

The same factors, of course, apply to medicine as a whole. While representatives of the medical profession have always tended to regard their activities as autonomous, it has become increasingly apparent that a wider perspective is needed to meet the requirements for proper provision of health care. The sociologist Merton (1957) put the case succinctly: 'Medicine is at heart a polygamist, becoming wedded to as many of the sciences and practical arts as prove their worth . . . As is often the case with polygamy, the set of wives—say, the biological and chemical sciences, are reluctant at first to approve yet another addition to the menage. But there is still hope. As the burden of work plainly becomes more than can be managed by the present members of the household, they become ready for new accessions to help carry the load of what needs to be done'.

Though there is an outmoded touch of male chauvinism in the metaphor, its force has become increasingly apparent as medicine struggles to incorporate its psychosocial component. Psychiatry demonstrates the same pattern still more clearly. Only when the discipline can count on a steady influx of medically qualified graduates of the highest calibre will its future be ensured.

Interdisciplinary training

One approach to improving interprofessional relationships and understanding can be by interdisciplinary training, not only by shared courses at a postgraduate level but also possibly at an undergraduate level. Such courses, which are already in operation at 'health sciences universities' in some other countries (Organisation for Economic Cooperation and Development, 1977) could draw applicants with both science and arts 'A' levels and include the study of biology, psychology, social administration, and sociology. The course would consist not only of formal instruction, but also of practical placements in settings dealing with health and social welfare, such as a nursing placement, medical clerkship, attachment to a general practice, attachment to social workers, clinical psychologists, and so on. At the end of such an undergraduate course there would be a number of career options open which, with further appropriate postgraduate education, would include nursing, social work, psychology, medicine and psychiatry.

Interdisciplinarity in clinical practice is well exemplified in such bodies as the Association of Therapeutic Communities set up in Britain in 1972, and is a key concept of the internationally accepted policy for improved health care on an international scale (World Health Organization, 1981), the bold and enlightened 'Health for all by the year 2000 through primary health care'.

Clinical responsibility and the multidisciplinary team

The needs of psychiatric patients are such that they can only be adequately met by a combination of a variety of professional health personnel. A multidisciplinary team is widely accepted as an appropriate way of working, but psychiatrists have often, and perhaps rightly, been criticised for their tendency to make autocratic decisions about patient management without due acknowledgement of other professions constituting the team. Such a team approach can only be effective in patient management with adequate recognition of the skills and abilities that each profession brings.

The issue of clinical responsibility has proved problematic and has been cited often as a reason why the psychiatrist must have final say in any team decision. In the National Health Service as it is structured at present, a medical practitioner has ultimate clinical responsibility for every patient within the service. However, each practitioner is responsible for his or her actions, and for adhering to the relevant professional ethical code. As concerns clinical psychologists, for instance, there is no necessity that the responsible medical practitioner be a psychiatrist, and it would be inappropriate to refer to many of

the activities carried out by clinical psychologists as medical in nature. The question of ultimate clinical responsibility is clearly an important one and if other professionals are to share the work of psychiatrists, both within and outside hospitals, the issues will need to be clearer for each different profession.

EMPHASES

17.1 Psychiatry calls for contributions from a variety of helping professions. In this context psychiatrists must define their own areas of competence and expertise more clearly (particularly the primary health care aspect of psychiatry), recognising the multiple roles that they may be required to occupy, but also accepting the limits of their abilities.

17.2 Each professional working in the mental health field should be better informed about the education, training, and the structure of related professions.

17.3 Some psychiatrists should be trained and prepared to take on more administrative, teaching, and supervisory duties, as clinical psychologists, social workers, and nurses extend their own skills in the prevention or relief of psychiatric illness.

17.4 Clinical psychiatry should become more community oriented with greater liaison between psychiatrists and general practitioners.

17.5 There must be better training for general practitioners in psychiatry and for psychiatrists in primary care.

17.6 Long-term planning should include serious consideration of the proper place of interdisciplinary training for mental health professionals.

17.7 As psychiatrists define more clearly their own contributions and functions in the care of the mentally ill, the emphasis in recruitment to the profession should always be on quality rather than quantity.

17.8 The issue of ultimate clinical responsibility in the multidisciplinary team must always be clear as different professionals combine their resources.

18 Future patterns of services

The pattern of services in psychiatry is relevant to recruitment because it determines the kind of work that psychiatrists will be called upon to do in future. Certain patterns may be less likely to attract good trainees than alternatives which lead to greater career satisfaction.

The present pattern

Policy issues 1971–1981

The decade began, particularly in England and Wales, with plans to run down mental hospitals and develop psychiatric units within general hospitals. Partly as a result of lack of money, these plans have not been implemented fully and a mental hospital is still the focus of many district services. Many mental hospitals are likely to retain this position in the years to come, especially where they are well sited within the area they serve.

With regard to manpower, the Department of Health and Social Security has proposed a progressive increase in the number of psychiatrists in England and Wales. In the first half of the 1970s, this was quite rapid; the growth between 1977 and 1980 in England and Wales was: consultants and SHMOs with allowance, 1045 to 1083; senior registrars 262 to 288; registrars 659 to 691; senior house officers 554 to 738 (GB, DHSS, 1978 and 1981). In terms of population, the consultant staffing for England and Wales was: general psychiatry, one consultant per 46,000 population; child psychiatry one per 181,000; mental handicap one per 330,000.

The attractions of psychiatry in the present services

At the present time the attractions of a career in psychiatry include: the special opportunities to work with the personal aspects of patients' problems, good career opportunities in an intellectually stimulating subject which brings together the 'biological' and social aspects of medicine, and the improvements in treatment achieved in recent years.

Causes for career dissatisfaction in the present services

Several factors which contribute to career dissatisfaction include the working environment, staffing levels, the nature of the patients treated, public attitudes, and the rival attractions of other medical work. Each of these factors will be considered in turn.

1 Poor working environments: the older mental hospitals are generally unappealing places in which to work, even though the quality of work within them is frequently high.

2 Inadequate staffing: although the staffing of mental hospitals has improved, many are still understaffed by modern standards. Low levels of staffing also exist in many general hospital psychiatry units. When consultants are too busy they cannot spend enough time with each patient, and personal and interpersonal problems cannot be explored fully. Thus the psychiatrist does not get to know most of his patients well, and can seldom provide psychotherapy. In this way he is prevented from carrying out those parts of his work which may have attracted him most when he chose the job in the first place.

3 The nature of the clinical problems: patients with chronic mental illness and severe personality disorders may be difficult to help, and less likely than other patients to make the doctor feel that they appreciate his help. Nevertheless, the care of people with even the most chronic problems can be rewarding if there is time to provide relief to the patient and those around him. On the other hand, prolonged contact with mentally disordered patients can be stressful for doctors (and of course for other staff as well).

4 Public attitudes: despite much progress in recent years, some negative attitudes still attach to aspects of psychiatry and these may discourage potential recruits.

5 The appeal of other medical work: in the last decade general practice has become substantially more attractive to young doctors, especially to those who share the psychiatrist's interest in people and their social and emotional problems. It is especially from this group of young doctors that future psychiatrists will be recruited.

6 Excessive administration: although management is an essential part of the psychiatrist's work, in some parts of the service administrative burdens are so heavy that they leave too little time for clinical work with individual patients.

The views of general practitioners

Many patients with psychiatric problems are treated by general practitioners. The psychiatric services provide for the patients that family doctors are unable to treat themselves. While some problems clearly have to be treated in hospital (for example, acute psychoses), the care of others can be divided in varying ways between primary care teams and hospital workers. It was therefore relevant to ask what psychiatric services general practitioners require (Crisp and others, 1984). For this reason, Preparatory Working Party 14 sought the views of a group of south London general practitioners about the services they would find useful. This survey's findings may not, of course, represent the views of practitioners in other places:

a. More than half the respondents considered the following provisions particularly useful: outpatient appointments for adults; inpatient facilities for psychogeriatric patients; emergency consultations for the mentally ill; the admission of mentally ill patients both voluntarily and under the provisions of the Mental Health Act; and domiciliary consultations. Day hospital and day centre provisions were also valued.

b. Of these general practitioners, 85 per cent said they would attend demonstrations and discussions of psychiatric problems and 60 per cent would value a psychiatrist working in the general practice premises. Nearly a quarter said they would be interested in a clinical assistantship in psychiatry.

The views of consultant psychiatrists

As well as the views of general practitioners, it is also relevant to know what psychiatrists think about the present services. The Working Party carried out a survey of a sample of consultant psychiatrists working in various parts of England and Wales—in both rural and urban areas and inside and outside London. (The sample was not, of course, necessarily representative of all consultant psychiatrists.) Among the replies, the following may be noted. Although these respondents acknowledged the merits of psychiatric units placed in general hospitals, they were concerned about inadequate numbers of beds in some of these units, and the inability to admit certain kinds of patients. There was also general agreement that mental hospitals should not be run down until adequate new facilities were available. Moreover, in deciding the role of a particular mental hospital in future services, its siting is a key consideration. Respondents also referred to the increasing difficulties in providing adequate care for psychogeriatric patients, and to excessive administrative tasks (Crisp and others, 1984).

The future pattern of services

It seems likely that psychiatric services, which need to relate closely to community provision, will continue to be organised mainly on the basis of catchment areas. It is important that these arrangements should not be so rigid that they preclude referral of patients across boundaries to obtain special expertise or special facilities.

As noted above, within the catchment area each consultant psychiatrist will need adequate time to devote to individual cases. To decide what is adequate, services need to be investigated to determine more accurately the time needed to provide a good standard of care. The consultant should also have time to evaluate his work, develop a research interest, and keep up with his subject. Without these opportunities consultants will not be well fitted to adapt services to new discoveries and changing demands. For this reason, any assessment of the realistic workload of psychiatrists should include due allowance for continuing education. It is likely that such a review will indicate the need for a substantial increase in the number of consultants. If in future there are fewer trainees per consultant, each of the latter will need to undertake more 'routine' duties in return for the greater opportunities to spend time with each of his patients and to undertake continuing education. Also, the number of hospital practitioner posts may need to be increased.

There is likely to be an increased emphasis on work outside the hospital by medical, nursing, and other professional staff. This work could be linked closely with that of general practitioners and with social workers and others working in the community. It would be appropriate to assess the extent to which money spent on well-staffed crisis services can reduce hospital admission and thereby reduce other costs. At the same time, the continuing care of incurable patients (the 'asylum function') must not be neglected. The proportion of elderly patients requiring psychiatric care will increase further. It will be important to ensure that elderly demented patients are not simply admitted to mental hospitals to take the place of their more acute patients, and essential to plan community services for these elderly demented patients.

The role of the older psychiatric hospitals in the future pattern of services has still to be determined finally. The Royal Commission on the National Health Service (1979) 'thought the mental illness hospitals needed to be rescued . . . We could find no sign of the nation being able to dispense with them in the foreseeable future.' Although there is no clear advantage in retaining those remote from the community they serve, well sited psychiatric hospitals may continue to play a useful part. If such hospitals are retained, it is essential that

they should not become second class institutions dealing with difficult patients who have been rejected by the newer units. If this is to be achieved, units based in general hospitals will require provision for the care of chronic disability as well as for acute episodes of illness, either within the curtilage of the district hospitals or in separate units in the community. Some community units will need to provide for special problems such as alcoholism and drug addiction. Children's services will need separate organisation.

As well as the services provided for each district, there will continue to be a need for specialist services serving a larger population, such as a health service region. Not all of these should be in teaching hospitals, although all should have close links with the medical schools, and all should engage in research, including the evaluation of the services they provide.

A conference on 'Mental Health Services in Pilot Study Areas' of the Regional Office for Europe of the World Health Organization held at Trieste on 10–13 April 1984 urged further training focused on non-institutional mental health care. Social pressures for change in the mental health services were recognised as widespread, but the present economic climate inhibited the expansion of these services.

The government of the United Kingdom, with all other nations, in 1979 adopted the resolution of the World Health Assembly by which member states undertook to formulate national policies and plans for providing primary health care (which includes prevention and promotion of health, with fostering of community participation). Identification of the primary care components of psychiatry is a pressing challenge which needs to be energetically taken up (Walton, 1985), to devise ways of responding better to the contemporary health needs of communities.

The future pattern of psychiatric services in Britain cannot be considered without attending to the future pattern of training. If a decision were taken to centralise most psychiatric training on teaching centres, it would still be necessary to give trainees some opportunity of gaining experience in peripheral hospitals; otherwise, they would be incompletely prepared for the work in non-teaching centres that most consultants would be undertaking. Hospitals that are not regularly engaged in training psychiatrists should be encouraged to be particularly active in training others—general practitioners, nurses, and other 'paramedical' staff. Public education will also be an important part of the work of psychiatrists, wherever they work.

If future consultant psychiatrists are to spend more time working in the community, away from their peer group of consultant psychiatrist colleagues, two changes in training need to be considered. The first is

to make it possible for more trainees to work in general practice as part of their training. The second is to encourage senior registrars to undertake more work outside hospital, to gain experience in initiating and evaluating novel aspects of service (with appropriate advice and supervision), and to play a greater part in administration. By the final year of training, senior registrars should be taking substantial responsibilities so that the move to the role of consultant is a gradual, not an abrupt transition.

These new provisions will require more to be spent on the psychiatric services. Although some of this funding may come from resources released by the total or partial closure of old hospitals, good community care is not likely to be a cheap option.

19 The wider prospect

A context needing final comment is the recognition of the professional consequences which follow from the fact that the United Kingdom is a member country of the European Economic Community, and doctors of any member state have been allowed to practise medicine anywhere in the EEC since 1976 (Walton and Binns, 1984). Very few doctors have in fact availed themselves of the right to settle in other countries, only about 1,000 each year. (A third are Irish doctors registered in the UK, a right long anteceding the EEC provision). Almost half of migrating doctors go to the UK, absorbed by the National Health Service.

The general and widespread acceptance in 1948 that Britain's health service should be both comprehensive and free was a most remarkable social phenomen. The NHS is a unique experiment in social engineering (Klein, 1983). It is the largest national employer, and the only service in the country which is comprehensive in the sense of looking after the entire population. Internationally it is also unique, as the only national health care system, centrally financed and directed, operating in a pluralistic political environment. (Sweden, which comes closest to the British model, delegates responsibility for health care to local government.) The monopolistic organisation of health care in the British model resembles the Communist countries, but they of course differ in that their political system is also monopolistic.

The report of the Royal Commission on Medical Education (1968) was the first review of the training of doctors after the founding of the NHS in 1948: the Royal Commission advised an expansion in medical manpower, the creation of new provincial medical schools to train this greater number of doctors, and confirmed that provision of postgraduate medical education must be a main consideration for all junior hospital doctors in the NHS.

Economic considerations cannot be ignored in the education and training of doctors. In the United States educational costs are steadily rising and the financial aid available is diminishing: these financial considerations help determine who will apply to, be accepted for, and graduate from a US medical school (Johnson, 1983). In the UK, financial considerations are not as constraining.

In the UK all medical students are taught in the clinical facilities of the NHS, and all future hospital specialists are trained while holding

junior hospital doctors posts in the NHS. All university clinical teachers have honorary appointments with the NHS; all NHS consultants are also medical teachers, as part of their normal contracted duties. The UK is thus an example of a country where medical education is provided in the closest association which can be achieved between the universities and the health service.

Fortunately for the UK there exists a University Grants Committee (Dainton, 1983), interposed between the government which provides funding on one hand, and the universities which they fund on the other hand. That prevents the extreme shifts in university funding and policy which can sometimes occur so disruptively in countries lacking such an intermediate administrative structure to protect higher education institutions from sudden politically-based upheavals. It makes continuity of planning possible despite changes of government, a boon absent in some other European countries where the university system and postgraduate training can be buffeted in direct consequence of changes in government.

The NHS and the universities, two great publicly-funded services, have many separate objectives, but both are alike in the stake each has in education and research in medicine. Despite such common allegiance, too few people in one of these services understand the chief purposes and problems in the other. A major weakness, on both sides, has been the imperfections in the interface between NHS and the universities.

Closer collaboration between the medical education system and the health care system is a highly necessary development for the future. In the UK, the aim must be to achieve still greater and improved cooperation and communication between the educational bodies, particularly the university, and the health services, and at local level between the medical school and the area health authority.

An essential component of proper medical education, therefore, is good and extensive cooperation between the medical care system and the medical education system in a country. At the worst, present arrangements must not be allowed to deteriorate; at best, the medical schools ought to be enabled to contribute still more powerfully to the health care provided for the population. The health service should make provisions for all the settings in which medical care is provided to be educationally available. These requirements for extension of the training settings, in which to produce doctors fitted to deal with changed health needs of communities, have yet to be achieved in the United Kingdom.

Each year the UK now spends 5.9 per cent of the Gross Domestic Product (GDP) on health care, medical education and medical research, as much as is spent on the whole of defence or education.

The NHS costs about £13,000 m, which is 6.2 per cent of the GDP, employing 820,000 people in providing free health care (less that 10 per cent of them doctors).

The NHS is now failing to meet the demands of patients in a number of respects (Klein, 1983; Illiffe, 1983). Such failure on its part will inevitably affect medical education and training, substantially based as these are in NHS clinical facilities, and any prospects of further deterioration give cause for concern.

The UK remains committed by all the political parties to the NHS, but at the same time private medical care is certainly a growing sector. There are attempts afoot to establish the first private medical school in Britain, a development opposed by the British Medical Association, and also by less organised opposition from medical educators and planners.

In the United States there is fairly general recognition and wider acknowledgement that the bodies responsible and the organisations designated for provision of medical services are certain to undergo massive and rapid change. 'The principal providers of medical service in the near future are likely to be physicians employed by large corporations or by health service organizations covering specific population groups' (Association of American Medical Colleges, 1984). The traditional view is being abandoned in North America that medical care is a social service, and is being replaced with the concept that it is an industry. Strategic planning will increase the medical 'products' identified and marketed, corporate restructuring is in progress, and multiple for-profit medical businesses are proliferating. Planners and medical teachers in the United States are aware that biomedical science, clinical medicine and medical education will all be greatly influenced by new financial arrangements and provisions. It can be expected that in the UK as well such future fiscal developments will have their effect, as yet scarcely even envisaged by medical teachers and educational bodies. Meanwhile education and training for medicine and its specialties in the United Kingdom has advantages and strengths which need to be recognised and fostered.

Appendix Education and training in psychiatry, conference at the King's Fund Centre, London, Wednesday 16 November 1983

Organised by the Steering Committee of the March 1982 Cambridge Conference

Chairman:	Professor Henry Walton
Rapporteur:	Dr K Michael Parry
Sessions introduced by:	Professor M G Gelder Professor S Brandon Professor K Rawnsley Dr C Peter Brook

Those present:

Dr J W Affleck	Royal College of Physicians, Edinburgh
Dr J A D Anderson	Professor of Community Medicine, London University
Mr Tim Bacon	Wyeth Laboratories
Dr J L T Birley	Royal College of Psychiatrists
Dr Kerry Bluglass	Medical Women's Federation
Professor R S Bluglass	Royal College of Psychiatrists
Professor Michael Bond	University Grants Committee
Ms Jane Boyce	Royal College of Psychiatrists
Professor S Brandon	Member of the Steering Committee of the Cambridge Conference
Dr Dallas Brodie	Trainee Representative
Dr C P Brook	Member of the Steering Committee of the Cambridge Conference
Dr Fiona Caldicott	Royal College of Psychiatrists
Dr I G Christie	Royal College of Psychiatrists

Professor Anthony Clare	Small Grants Committee, DHSS/Mental Health Foundation
Dr J Connolly	Association of University Teachers of Psychiatry
Professor Arthur Crisp	General Medical Council
Dr F J Fawcett	Postgraduate Dean, East Anglia Regional Health Authority
Dr Hugh Freeman	Editor, British Journal of Psychiatry
Professor M G Gelder	Member of the Steering Committee of the Cambridge Conference
Professor David Goldberg	Association of University Teachers of Psychiatry
Dr David Gordon	The Wellcome Trust
Dr Harry Hall	Chairman, Central Manpower Committee/Joint Consultants Committee
Dr Julie Hollyman	Royal College of Psychiatrists
Dr L F Howitt	Scottish Home and Health Department
Dr O Lakhanpaul	Overseas Doctors' Association
Dr G A Mogey	Council for Postgraduate Medical Education in England and Wales
Mr Michael Powell	Committee of Vice-Chancellors and Principals
Professor K Rawnsley	Member of the Steering Committee of the Cambridge Conference
Professor G F M Russell	Association of University Teachers of Psychiatry
Dr B Sacks	Royal College of Psychiatrists
Dr R Scorer	Member of the Steering Committee of the Cambridge Conference
Professor C P Seager	Royal College of Psychiatrists
Professor A C P Sims	Association of University Teachers of Psychiatry
Dr Robin Steel	Royal College of General Practitioners

Dr Chris Thompson	Trainee Representative
Dr Wendy Thorne	Department of Health and Social Security
Dr Clive Tonks	Association of University Teachers of Psychiatry
Dr P J Tunstall	Community Medicine Specialist (Special Services), Mersey RHA
Dr Helena Waters	Member of the Steering Committee of the Cambridge Conference
Dr Yvonne Wiley	Royal College of Psychiatrists
Sir Henry Yellowlees	Chief Medical Officer, Department of Health and Social Security

Introduction

A one-day conference on topics of importance in education and training in psychiatry was held on 16 November 1983 at the King's Fund Centre in London. The meeting was organised as a follow-up to the national conference held in March 1982 in Cambridge. The meeting was specifically designed for a selected audience of medical educators, health service planners and administrators, and representatives of regulatory and of funding bodies. The aim was to draw attention to some current issues of education and training in psychiatry and to outline future developments which were of concern to the various bodies represented at the conference.

Four issues were discussed: recruitment to academic departments and for research; the maintenance of postgraduate training in the face of cuts in both university and NHS funds; overseas trainees; and continuing education for consultant psychiatrists.

Academic departments

a. University departments of psychiatry were relatively young compared to other clinical departments and had not had time to build up adequate resources. They lacked supporting staff and, particularly outside London, had an inadequate number of attached NHS clinical teachers. Yet the burden upon undergraduate departments was increasing because of demands such as behavioural science teaching and psychiatry teaching to an increasing number of medical students.

b. Psychiatric teaching was particularly labour intensive, calling for close supervision of medical students and those in psychiatric training, and the consequential pressure upon a small academic staff was aggravated by the substantial load of patient care which was notably time-consuming.

c. Psychiatric research was by nature long-term and hence incompatible, or at least extremely difficult to reconcile with, current patterns of post-graduate training in psychiatry which put considerable pressure upon trainees to follow a prescribed pathway to recognition for later consultant status. This adversely affected recruitment to academic psychiatry and commitment to research, diminishing invaluable manpower resources.

d. Physical resources for psychiatric clinical work were invariably divided between small teaching units and larger, usually more remote, psychiatric hospitals. These arrangements resulted in an inadequate base for research and an inefficient use of time, particularly where academic units were expected to assume a clinical service as well as a university commitment.

Although there had been an undoubted and welcome recent improvement in recruitment to psychiatry, there was a most frustrating lack of university resources to respond to these new opportunities. There was insufficient appreciation of the particular problems of academic departments in psychiatry; too few whole-time posts were funded, and there was inadequate recognition of the need for joint NHS/university posts. Although the need for flexibility in postgraduate training was acknowledged formally, it did not work well in practice and, understandably, young psychiatrists felt obliged to comply with the recommended programme of the Joint Committee on Higher Psychiatric Training which sometimes conflicted with a commitment to research.

In discussion, although evidence was given of an increase in the total research expenditure in psychiatry, with some increase in research posts, this relative increase in soft money was creating a problem in obtaining honorary senior registrar status for some lecturers and research workers, and their contribution to teaching was variable. In the longer term the ratio between the number of students and permanent teaching staff was liable to deteriorate, and this would be further eroded if the gap between the material rewards of academic as opposed to NHS appointments was allowed to increase. The current trend towards a variety of lucrative additions to basic NHS salaries through extra duties and private practice could seriously undermine recruitment to academic departments.

The NHS had responded to University Grants Committee cuts by assisting some academic departments, but priorities were determined by service rather than academic needs. This unbalanced the medical faculties; unless this was recognised by the UGC, teaching and research requirements would be unduly biased towards the immediate needs of the NHS. Further difficulties were being created by the growing popularity of rotational NHS training programmes which in psychiatry almost invariably started immediately after full registration. This not only gave little time for young graduates to gain experience in a variety of other specialties before commit-

ting themselves to a psychiatric career, it militated against young academics pursuing research in any depth.

At a more senior training level there was a real conflict of interest between medical manpower planners and academic departments. Despite the understandable desire of the planners to limit the number of honorary and NHS senior registrars to the predictable number of vacancies for permanent posts in both universities and the NHS, the number was not easy to predict. The prescribed period of higher training was further called into question by the different rate of progress of individuals, the availability of consultant vacancies, and the different requirements of research. The rigid control of the number of senior registrars conflicts with the variable needs of academic departments for both teaching and for research; doubts about being accorded honorary senior registrar status already seriously undermined the recruitment to university posts of promising individuals who, understandably, needed assurance that the pursuit of academic work would not lead down a blind alley.

Central funding agencies were interested in ways in which they could assist individual university departments, but at present there was no standard way in which information was collected and this made the interpretation of information difficult. There was a variety of ways of improving staffing, including restructuring within a medical faculty which could lead to a more efficient use of resources. Scope for 'new blood' appointments needed to be exploited but the case for these sometimes failed to satisfy the UGC's interest in monitoring its investment in tangible terms. Particular problems were well recognised; for instance, the behavioural sciences were known to suffer from some lack of interest from students, from unevenness in course design and from antipathy from other faculty departments, some of which —such as the basic sciences—were facing recruitment problems. Research bodies were also not necessarily sympathetic to behavioural research with social rather than biological emphasis.

Postgraduate training

The NHS was committed to providing postgraduate education and training for its medical staff; this included supervised clinical experience for those in the training grades and continuing education for all. Quality was controlled by the royal colleges and joint higher training committees in association with academic bodies, and throughout the country university departments played a key role in all aspects of postgraduate education. They were able to provide a full and balanced education, and training was likely to continue to be based upon academic centres. This put a heavy burden upon the universities and had also implications for 'non-teaching' centres where there was a need for a significant improvement in the volume and quality of continuing education, particularly for doctors who were not engaged in postgraduate training. For them postgraduate medical education centres

were extremely important but these centres were now used by many specialties and other disciplines whose large numbers and different needs could be a cause of conflict.

Teaching at all levels—from undergraduate to continuing education—needed the support of well-founded university departments of psychiatry, but there was no UGC support for postgraduate education which did not lead to higher degrees, and health authorities often did not provide sufficient funds for the necessary secretarial, equipment and manpower costs of postgraduate teaching. NHS constraints also inhibited the development of well-planned inservice training programmes because the location and content of training posts were often dictated by service rather than by training requirements. The position in psychiatry differed from other specialties in that training was particularly labour-intensive, and the recent dramatic improvement in recruits of higher quality had given rise to a demand for corresponding and rapid improvement in the quality of training and of standards of service.

Higher priority in the provision of resources for postgraduate education and training in psychiatry at a time of restricted expenditure would reduce levels of service in the immediate future, but improved quality and changing patterns of practice would bring significant benefits in the longer term.

There was no standard solution to the problems of medical manpower: each specialty should be considered separately. The imbalance of the training and established grades which affected other specialties did not necessarily apply in psychiatry, where expansion of the consultant grade was urgently needed. Dialogue with other specialties was necessary, however, to ensure balanced postgraduate training. Patients with emotional and psychological problems were encountered in all branches of hospital medicine and general practice; the need for a strong psychiatric component in multidisciplinary teaching was clearly evident. Training programmes in psychiatry as a specialty should be planned on a wider basis than individual hospitals where local manpower difficulties could seriously interfere with satisfactory training. There should be closer collaboration between accreditation bodies and regional committees to ensure that the total needs of a region were considered. The training of other disciplines in psychiatry should be taken into account as well as that of career psychiatrists. Senior registrars needed experience not only of the several specialties of psychiatry but of the general responsibilities of consultants, including management. Consideration should also be given to the selection and training of trainers, whose work-load should be such as to give adequate time to clinical teaching. This may lead to more centralisation of training and a significant number of consultants having no postgraduate teaching responsibilities. Training should not, however, be limited to teaching hospitals; doctors in training should have experience of work in peripheral hospitals where many would become consultants.

Medical faculties were in difficulty as compared with others because neither their postgraduate teaching activities nor their heavy service commitments attracted revenue for the university. The NHS was responsible for meeting the cost of most postgraduate teaching but the only benefit to the university was indirect—the considerable undergraduate teaching provided by honorary teachers. Many health authorities gave direct help to university departments but this was variable and did not assure stability in university departments.

Training overseas-qualified doctors

Two case histories were described at the meeting to illustrate the current arrangements. A male Indian graduate aged 30 came to the United Kingdom to stay with a cousin in Birmingham and to seek surgical training. After being unemployed for six months he obtained a clinical attachment in surgery and sat the PLAB test, passing on the second attempt. He then discovered fierce competition for surgical posts and after consulting the National Advice Centre took up an SHO post in psychiatry. He had, however, no real interest in the discipline and failed the preliminary test of the MRCPsych at each attempt. He remained in the SHO grade and faced the end of his five year period of limited registration with alarm.

His experience was contrasted with that of a 28-year-old graduate of Baghdad who was financed by his government to come to the United Kingdom for training in psychiatry under WHO sponsorship which exempted him from the PLAB test. He was given a clinical assistantship in London and passed the preliminary test on his second attempt, obtaining the MRCPsych in three years. He was now returning to Iraq.

The majority of overseas doctors were unsponsored, as in the first case cited, and since many came to the UK with wholly inadequate information about the postgraduate training they might receive and often vague ideas about what they sought, disillusionment and frustration was widespread. They were prone to find themselves limited to SHO posts in psychiatry and geriatrics (both specialties where understanding to the cultural background is imperative) in settings least favourable to their postgraduate training. This could be seen from the percentage of overseas-qualified doctors in the specialty of mental illness as compared with surgery; in the former the percentage of overseas-qualified consultants, senior registrars, registrars and SHOs was 19, 39, 64 and 63 respectively. In surgery the percentage was 9, 16, 52 and 71. In actual numbers there were 804 consultants and 130 senior registrars in psychiatry who graduated in the UK compared with 190 and 88 overseas graduates, whereas 401 of the registrars and SHOs were UK graduates but 703 were from overseas. The problem does not affect psychiatry alone; overall a quarter of all doctors in the UK and a third of all hospital doctors had qualified overseas.

The UK had a long tradition of providing postgraduate education and training for overseas doctors and in return these doctors had provided support for the NHS. This implied a moral debt, particularly to those who came to the UK in good faith but encountered difficulties in obtaining satisfactory training while they provided service.

In theory these problems in future would be resolved if there was a satisfactory response from educational bodies and health authorities to the plea of the General Medical Council for better sponsorship arrangements, but there were several practical problems, such as to ensure justice to UK graduates when limited training opportunities were earmarked for overseas doctors, and guaranteeing that the latter would return home after training.

Sponsorship schemes would not, however, overcome the dilemma of the large number of overseas-qualified doctors presently in the UK. Their future was extremely uncertain because of the rigid hospital staffing structure of the NHS, and many felt unable to return to their home countries. While sponsorship schemes were being developed, it was imperative that any doctor seeking training in the UK was fully and effectively counselled.

Continued provision for the training of overseas doctors in psychiatry in the UK was welcomed although it was stressed that patterns of service in other countries were often very different and this needed to be taken into account. Selection was important since the quality of undergraduate teaching in psychiatry in overseas countries was very variable.

There was a paramount need to introduce new and better control mechanisms for the predictable number of training opportunities in the UK. Patterns of training were changing; the early stages were expected to involve training in more than one discipline and this would require complex planning, geared to the needs of the NHS. UK training programmes may not be appropriate for some overseas doctors; this did not mean that they should not be provided for, but their particular needs should be identified and related to the training resources of the UK. It could not be assumed that current resources, including those of medical manpower, would remain stable in the face of the reduction of public expenditure.

There was mixed opinion on the need for a permanent non-consultant grade; this was considered unsatisfactory for UK graduates and generally opposed by the profession. Nevertheless, there was a particular problem for some overseas doctors who had not succeeded in progressing along specialist training pathways yet wished to continue to work in the UK and were able to provide useful service. Each specialty needed to consider its own medical manpower problems and general solutions were not always appropriate.

Continuing education

The continuing education of consultants was of great importance because of advances in knowledge and the likelihood of radical changes in the ways in

which psychiatrists worked. There was increasing dependence on other professionals, a greater emphasis upon work in the community particularly with the primary care team, expansion of consultant/liaison psychiatry and—for some consultants—the possibility that they would work without trainees in the future. Continuing education would be a major factor in maintaining standards and morale and, therefore, needed to be available to all consultants; this would be the responsibility of the Royal College of Psychiatrists, the universities and the National Health Service.

Examples of educational activities included opportunities to discuss topics of mutual interest with others, either at a national or local level; distance learning techniques, which would be of particular value to relatively isolated doctors; engaging in research, which would often call upon the assistance of a local university department; opportunities to visit centres of excellence; attendance at conferences and workshops which would provide yardsticks by which consultants could measure their own standards of practice; and an opportunity to change career by switching to another psychiatric specialty or by developing a special interest.

Peer review and audit would need to be more generally introduced. Some activities would take place at a national level (such as the Royal College's enquiry into the use and practice of electro-convulsive therapy) but most would be conducted locally. The need for continuous evaluation of services provided by individual consultants and their colleagues could be met informally by means of case conferences, and by divisions of psychiatry examining different aspects of the service they provided. Audit would be facilitated by improved record-keeping and better statistical analyses. Additional resources would be needed for continuing education to allow for more study leave, sabbaticals and the strengthening of exiguously staffed university departments of psychiatry. Facilities for peer group leaders to acquire necessary skills were also needed.

Incentives for consultants to take part in continuing education were needed to overcome natural resistance and suspicion. Demonstrations of various forms of continuing education could elicit interest, and valuable lessons learnt from the Royal College of General Practitioners which insisted upon its recognised trainers participating in continuing education. Dependence upon other medical disciplines, however, should not be assumed. Help from community medicine specialists with epidemiological studies and in the analysis of data would be most welcome, but their resources were under considerable strain and psychiatrists should acquire their own epidemiological skills. Reliance upon academic departments would also be severely restricted because of their limited resources.

The effective use of limited resources was a good reason for the development of distance learning quite apart from its value to relatively isolated doctors. Participation would be materially affected by the quality and relevance of programmes, and although a case could be made for additional

investment by the NHS in anticipation of a consequential improvement in the quality of service, cost limits meant that monies would have to be found from some other NHS commitment. It was suggested that, as in the United States, doctors should contribute personally to the costs of their own continuing education.

Continuing education was essentially a 'grass roots' activity. 'Centres of excellence' did not necessarily provide an appropriate model and the merit of distance learning was the dynamism it gave to individual doctors to take an interest in their own continuing education and the assessment of their practices. A recent review of continuing education in general practice had revealed enthusiastic young doctors, accustomed to small group work, developing effective learning groups and drawing upon a variety of learning aids. Self-dependency seemed to depend upon the creation of a 'critical mass' of local enthusiasts who were willing to work together and to assume responsibility for their own education. It was stressed, however, that there was no single solution to the development of continuing education; variety was needed to cater for individual needs and preferences.

The Royal College was committed to the development of continuing education and would take a lead in its promotion. Early priority should be given to an assessment of needs which were variable. Non-participants should be identified and their particular difficulties studied; incentives were invariably preferable to mandatory education.

Commentary

The momentum for change in the NHS and in education can be readily maintained within a budget which contains an element of growth in real terms. But tightly controlled cost limits and declining public investment imposes a severe discipline upon all who use government funded resources, and special problems for those who wish to disturb the balance of their distribution. The temptation is to close ranks and strive for the *status quo*, yet this distorts a proper assessment of priorities and conceals the scope for the better use of resources. Medical education faces particular difficulty because its various phases are in different hands, and sectional interests in postgraduate education militate against the formation of consensus and support for common objectives.

Special pleading for an expansion of psychiatric education will gain strength from outside its ranks only if its current resources are shown to be well used and the need for its growth reflected in changing patterns of patient services within the NHS. The conference helped to clarify a number of problems; solutions will be more elusive.

Academic departments of psychiatry are undoubtedly in greater difficulty than others. They have had less time to grow and their teaching mode is labour intensive. Health authorities have recognised the high quality of

service that they provide but there is a price to be paid for NHS resources, valuable though they are. Heavy service commitments, often in inaccessible sites, intrude into teaching and research time, and the pressure on academic units to accept increasing responsibility for postgraduate education and training, however desirable, threatens the quality which should be the hallmark of the university clinical department.

In an ideal world the faculty of medicine should distribute its resources according to the educational needs of its students; in practice sectional interests tend to prevail and attempts to broaden teaching strategies and consider such matters as topic and other types of integrated teaching become lost in the struggle to preserve each department. Modes of teaching which cannot be provided within standard staff/student ratios elicit little sympathy, however educationally relevant. Academic psychiatry is further handicapped within the medical faculty in that research work which is not seen to have practical objectives in terms of delivery of care attracts little enthusiasm, despite the convention that universities are proper places to pursue abstract ideas.

Frustration with the ordering of priorities by universities and their medical faculties understandably leads to calls for greater control by central bodies, particularly when they appear to be more in tune with the need for change in medical teaching. Both the UGC and the GMC, although ready to advise, rarely intervene in the detailed decisions of individual universities. Devolved authority is jealously guarded; a change in the balance of power may achieve short-term gains for disadvantaged minorities by overriding local parochialism and partiality, but in the longer term there is a strong tendency for central authorities to impose standard solutions which stifle individual enterprise and a variety of approach to common problems. Sapiential authority, which works by seeking consent and cooperation, is more time-consuming than line authority which controls purse strings, but it is more in tune with a free society which respects individuality and suspects bureaucracy.

Centralising authority for postgraduate education and training has rationalised training programmes and visits from colleges and joint higher training committees have helped to raise standards. But despite a stated commitment to flexibility, judgments on the acceptability of individual variations in standard training programmes are less easy to make centrally than locally. Concentration upon the needs of trainees already committed to the specialty of psychiatry has deflected broader consideration from the needs of the uncommitted and of those who seek a broad initial experience before specialising in another medical discipline. There is a risk, too, that the organisation of training will over-emphasise what teachers provide and underrate the responsibility which learners should themselves assume. Self-dependency in learning is especially important in postgraduate education, or doctors are going to be poor judges of changes which will inevitably

take place in a lifetime of practice. The teacher is not necessarily the best source of information; the model he provides and the values he communicates through behaviour far more than through words reflect the influence with the greatest lasting power. The best education for a doctor is the result of a difficult balance; it must include the acquisition of sufficient technical knowledge to enable him to do his work well in the technical sense, but it must also foster his critical investigative intelligence. That delicate balance should be reflected in the relationship between central and local postgraduate authorities, both of whom should recognise that the acquisition of clinical craft is but a part of the education of a member of a profession.

Lessons learnt from the organisation of vocational training should be applied to early attempts to rationalise continuing education. Here the hierarchy of knowledge between peers and the information dissemination role of teachers is less apparent. Nevertheless, the established doctor needs confidence and personal insight in the exercise of responsibility for his own continuing learning. He needs ready access to a variety of information, stimulus to assess his daily work, and the means of comparison with the work of colleagues in similar fields of practice. Self-assessment learning programmes are in small supply and skill in conducting small learning groups possessed by few. The need for their development is required universally in all branches of medical practice, and since the techniques are not peculiar to each specialty, scope for sharing technical resources should be fully exploited.

Psychiatry has attracted a disproportionate number of the uncontrolled influx of overseas-qualified doctors into the United Kingdom. In their interests and those of the psychiatric services of the NHS, steps are urgently needed to identify the learning needs of overseas doctors and match these with the resources of the NHS. The GMC's advocacy of sponsorship is to be warmly welcomed; there is, however, no single solution and educational bodies and employing authorities should all be actively seeking ways in which effective selection procedures can be introduced.

Summary

The meeting provided the opportunity for consideration of particular problems, and some useful indicators emerged:

1 Academic departments could usefully draw to the attention of medical faculties that the recent development of prescribed periods of postgraduate training for all disciplines relieves the medical curriculum of the now impossible task of trying to produce a 'safe' doctor; the contribution of each department should be seen in the context of a general education in medicine, and not in terms of acquiring competency in a particular discipline. Hence it should follow that the staffing needs of each department should reflect the overall aims of the medical course and not the more limited objectives of

individual subjects. It could be helpful if the GMC's Education Committee could complement its recommendations on basic medical education by indicating the balance of disciplines within a faculty which could best meet these aims.

2 Common terms and conditions of service within the NHS have led to a specialist staffing structure which is difficult to reconcile with the varying service and postgraduate teaching requirements of each discipline. Principles should be sufficiently broad to enable manpower solutions to be devised which are appropriate to each specialty, but in calculating the number of junior training posts account must be taken of the need of each discipline to acquire experience in others, and the right of young graduates to delay their commitment to particular careers.

3 Apprenticeship is the basis of postgraduate training, but 'learning by doing' needs to be supplemented by a variety of aids. Teaching is not simply an inherent ability and its skills need to be acquired; those who assume responsibility for the education of others should be as well versed in its techniques as in the practice of their profession.

4 Although there is no curriculum for continuing education it nevertheless needs as much careful planning and dedicated resources as any other phase of education. Distance learning programmes can provide the means of self-assessment as well digested information, but should be supported by small learning groups which require skilled preparation and coordination. Resources for the preparation of material for distance learning and courses for group coordinators can be shared by all medical and allied disciplines, and a redistribution of current financial commitments in continuing education should be considered by the profession as a whole. If additional funds are needed, account should be taken of the intellectual benefits which accrue to a professional person as well as improvements to the health service.

5 Psychiatry should continue to be included in the long established UK tradition of providing medical education worldwide, but this will require special efforts to overcome the problems that have arisen from the uncontrolled influx of overseas-qualified doctors to training posts in settings wholly inappropriate for their postgraduate needs.

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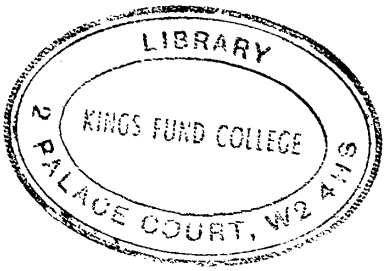

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