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Training matters

Achieving a balance: establishing a new regional scheme for psychiatric registrars in South East Thames

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Until recently, a doctor beginning a career in psychiatry would usually apply for a combined SHO/registrar rotation lasting approximately 3½ years. Trainees could expect promotion from SHO to registrar after about 18 months, subject to passing the Part I of the MRCPsych examination and also to their educational and clinical progress having been judged to be satisfactory by the scheme tutor and organising committee. Life has changed! The emergence of *Achieving a Balance* (Department of Health, 1988), the proposals of which are intended to be phased in over the next ten years, has meant that scheme organisers have had to quickly change the basis on which their rotations are run. This paper is an account of how this has been done in the SE Thames Region.

The South East Thames Regional Health Authority encompasses 15 districts. Hitherto, eight separate training schemes for SHOs and registrars had evolved, only two of which incorporated posts in teaching hospitals; a four district scheme involved Greenwich and Bexley, and also Lewisham/North Southwark and West Lambeth (the teaching districts of the United Medical and Dental Schools of Guy's and St Thomas' Hospitals), and the Camberwell Scheme which joined training arrangements at King's College Hospital to the Institute of Psychiatry. The other schemes, all approved by the College, were without university links. Dartford, Brighton, and Bromley have been single district schemes. Canterbury–Thanet/SE Kent, Eastbourne/Hastings and Medway/Maidstone/Tunbridge Wells were multi-district schemes.

On reading *Achieving a Balance*, with its emphasis on an ultimate reduction in registrar numbers and the division of registrars into 'career and overseas' categories, it was apparent to SE Thames psychiatric tutors and also to UMDS that registrar training should be arranged so that all trainees should have access to academic placements and also to the full range of psychiatric specialty experience. We wished to avoid any suggestion of a 'two tier' system. We were aware that the DOH has suggested that 'career' and 'overseas' registrars must have commensurate educational opportunities, a view echoed by the Royal College of Psychiatrists (Council of the Royal College of Psychiatrists, 1990). The outcome of these early discussions has been the emergence of two psychiatric registrar schemes in the region. Registrars in two districts (Camberwell and Bromley) link with the Special Health Authority Scheme while registrars in the other 13 districts would be linked with UMDS. The UMDS/SE Thames scheme has been provisionally approved by the College and the first appointments have been made to it. We comment here on the issues which have had to be faced during the planning leading to this point.

The educational needs of trainees are at all times of paramount importance

Initially clinical tutors from consistent districts met and attempted to delineate the special features of registrar training which seemed different from SHO training. It was decided that registrar posts should be those which require a sound knowledge of general psychiatry before full educational value can be obtained from them and we found that on this basis it was relatively easy to identify the posts in the former SHO/registrar systems which should be included in the scheme. The list included posts in substance abuse, child psychiatry, mental handicap, forensic psychiatry, liaison/consultation psychiatry, specialised therapeutic community work, academic units, psychotherapy posts and specialised rehabilitation. In addition, we noted that while the core skills required in general psychiatry were largely similar to those required in day hospital posts and newly emerging community mental health teams, trainees often work in these settings with more autonomy than in ward-based general psychiatry posts. Hence we decided that in our scheme, day hospitals and community mental health centres would provide suitable training at registrar level.

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Psychogeriatrics posed a problem. Although many psychogeriatric services offer a 'community-based approach', most psychogeriatric services include an assessment ward which we agreed should be staffed at SHO level. This is also in line with the College guidelines which state that psychogeriatric posts are suitable for SHO level (Part I MRCPsych) training. We judged that posts in specialised psychogeriatric community mental health teams could be filled by psychiatric registrars as with community-based posts in adult psychiatry. We decided that posts where the main task was to provide general medical care to long-stay psychiatric patients, or to long-stay psychogeriatric patients, provided little of educational value to trainees and should therefore not be training posts at SHO or registrar level.

An organisational structure is required which allows proper participation of trainers and trainees in all affiliated districts

Initial meetings were held between a UMDS representative (JLH) and organising tutors of the other collaborating schemes. As plans emerged, the other regional and College interests were represented in the discussions. An organising committee was formed, including psychiatric tutors from the six contributing schemes, Regional Adviser, UMDS Professor of Psychiatry, Regional Postgraduate Dean and Regional Medical Staffing Officer. Early in the discussion of the various issues involved in the dismantling of six existing schemes for SHOs and registrars and replacing the registrar component by one regional scheme, it was agreed that the existing schemes would maintain their separate SHO rotations. SHOs employed in these schemes will be eligible to apply for regional registrar jobs subject to competitive interview following national advertisement of such posts.

The scheme must have a plan for rotation which is practical and fair as well as educationally sound

The following scheme outline has emerged.

(a) Following appointment to the regional registrar scheme, it is expected that appointees may remain registrars in the scheme for three years subject to satisfactory progress. We would expect appointees to work for approximately 18 months in a peripheral centre within the region and 18 months in posts commutable from central London. Hence, no trainee should be expected to make a major change of work location more than once during their tenure in the registrar grade. Each placement would last for six months. Where a registrar is appointed who was previously an SHO in an existing South East Thames post, we would expect that the first 18 months of their registrar training should occur in posts commutable from their previous base. This suggestion was popular with a committee/trainee working party, in which we discussed these issues, because it minimises inconvenience to trainees as much as possible. It proved feasible to decide which posts are easily commutable from each base; fortunately the numbers of registrar posts in centres other than London and the numbers of posts commutable from a central London base, are approximately equal.

(b) It was helpful that the regional staffing office, who have statutory responsibility in the matter, agreed that the scheme organising committee can, with the addition of a lay chairperson, form the appointments committee for posts within the scheme.

(c) The setting up of training on a regional basis will necessarily mean that expenses are incurred which were not inherent in the previous training structure. We identified the areas which require funding and suggested that a budget should be created for these expenses. This requires regional agreement and a regionally organised structure in order to prevent disputes between participating districts, disputes which could become more frequent as NHS management and accounting systems improve. Doctors are likely to have increased travelling costs as they will often be moving from more than one centre in each cluster of London and non-London posts. Where doctors decide to move house at the mid-point of the scheme, removal expenses will have to be budgeted for as otherwise no local manager (medical or non medical) would wish to receive a trainee at the mid point of their rotation, bringing removal or increased travel expenses with them.

The answers to these important questions lie with the cooperative attitude of our regional medical staffing office who have agreed to take registrars onto the regional payroll, and constituent districts will be cross-charged for registrar salaries and also expenses. This mechanism will ensure that these expenses are shared fairly between the groups of districts through which an individual trainee rotates. This arrangement will cover maternity leave expenses which must also be fairly apportioned in a scheme of this sort. We are aware that women doctors on multi-district rotations have had difficulty in ensuring that these entitlements are actually paid without disagreements occurring about which district should foot the bill.

Trainees on appointment will realise that there will not be a standard UMT rate for each district in the scheme and that the UMTs will change with each post, depending on the on-call for the participating district, and this will form part of the contract for the

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rotation. Many trainees will not wish to move house at the mid-point of the scheme but may commute to their posts by train. If their posts require the use of a car, the provision of 'Crown' or lease cars should be considered.

Ideally, the administration of a scheme should be done by a senior clinician whose time is funded

There is no doubt that administering a large regional scheme makes significant in-roads into the time of the scheme organiser. We estimate that the organisation of our scheme will take approximately four sessions per week of consultant time and have suggested that funding should be made available for this. We believe that in a large regionally based scheme decisions should not be taken by a large committee remote from the trainees in the absence of an organiser actually having some detailed knowledge of each trainee in the region. However, in keeping with the general non-funding of postgraduate training in hospital specialties, no funds have as yet been identified for this particular function although a consultant organiser's travel expenses will be reimbursed by the region. There will need to be regular meetings between participating district consultants in the regional scheme and the scheme organiser in order to sort out any problems arising from the implementation of this scheme and in addition, meetings with trainees to ensure that their educational needs are being met. This should not supplant the work carried out by individual district clinical tutors.

Finally, there is no doubt that administering such a scheme will also require a consumables budget, e.g. paper, photocopying, telephone calls, etc., and allowance must be made for these expenses, as well as for secretarial/administration time. Perhaps the new arrangements planned by the Department of Health will provide adequate funding for these activities for the first time.

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Psychiatric knowledge and attitudes in Nottingham medical students

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Psychological and psychiatric issues represent a significant proportion of the workload of all doctors. Nonetheless junior doctors often have an unsatisfactory knowledge of psychiatry. Previous studies have examined how hospital doctors say they manage psychological problems (Mayou & Smith, 1986), and attitudinal factors among medical students (Wilkinson *et al*, 1983).

In Nottingham, medical students undertake an integrated course with a strong emphasis on the behavioural sciences, and on the psychological aspects of medicine, surgery, obstetrics and child health. It was therefore hypothesised that Nottingham students would be familiar with some basic psychological and psychiatric issues before they began their psychiatric clerkship. Similarly, the

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