Correspondence

Approval of psychiatric training in District General Hospitals

DEAR SIR

Recent visits by Approval teams to four District General Hospital Units in this Region have occasioned much anxiety which is now heightened by the advent of the Short Report.*

The East Anglian Region is extensive and thinly populated, with at least two of the District General Hospital Units more than forty miles from traditional mental hospitals, and accordingly they are being encouraged to become self-sufficient in the service they provide and have been encouraged to think that much of the psychiatry of the 1980's and 1990's will be practised in such a setting. This does lend itself to good relationships and close contact with colleagues in other specialties; it tends to cement good bonds with the GPs in the District, and it encourages the development of good community services, especially with domiciliary nurses and day centres.

The new chronically ill patients cannot be conveniently lost from sight but have to be provided for in this setting, so that all such acute units have to practise long-term thinking and planning, with rehabilitation always in mind but with the pace differing according to the patients' needs. The trend for psychogeriatrics is to look increasingly to the local community hospitals for their location; kind to them and their families, but difficult for junior staff supervision if all the juniors are clustered in mental hospitals, or teaching hospital units.

Furthermore, many a psychiatric training post in District General Hospital Units has been set aside for a GP trainee in the various vocational training schemes set up in this country, the tutors in general practice believing that there the GP trainees will see a representative sample of patients and gain a good grounding in psychiatry, whilst working in recognized posts alongside career psychiatrists also in recognized training posts.

But now come the snags. Perhaps some of these arise from the fact that in psychiatry, and only in psychiatry among all the specialties, it is not posts that are recognized and approved, but whole training programmes.

Typically in a District there will be three adult psychiatrists, very much generalists but dealing with alcoholism, addiction, court work, and the elderly mentally infirm of necessity. There will also be a child psychiatrist and a consultant in mental handicap. Hopefully there may come a time when there is also in every district a psychogeriatrician.

Such a District may, if the psychiatrists are fortunate, have three registrars who it is hoped can be effectively trained in adult general psychiatry, and in all the subspecialties, whilst having ample opportunity for liaison work in the nearby District General Hospital and being ensured day release for the Regional University MRCPsych. Course.

To ensure substantial experience in each of these areas of psychiatric training it is impossible to schedule it so that all consultants have a registrar all the time. It is possible and essential to ensure rotation from one consultant to another, thereby giving exposure to different styles, whims and fancies, and also to ensure changing attachments to the subspecialties but almost of necessity on a sessional basis.

Individual Sections of the College each seem to propose that trainees should be attached for six-month periods, and I note that this suggestion has just been put forward by the Section of Psychiatry of Old Age. Bearing in mind the College's own recommendation that every trainee preparing for the MRCPsych should have eighteen months in adult general psychiatry, it is difficult to conceive how everyone can ever have six-month stints in all the other fields.

There seems a determined wish by the College Approval teams to ensure that trainees should experience work in different settings and should spend some time in a traditional mental hospital. Obviously desirable, but the practice of rehabilitation with graded hospital to hostel care can be demonstrated in a District General Hospital Unit.

It causes me and other psychiatrists in this Region much concern that District General Hospital units working in isolation from mental hospitals do not seem to be deemed able to provide an adequate or varied enough experience. SHOs and registrars will not welcome being dislocated during a three-year training programme so that families have to be uprooted; but if approval of that training programme is at stake they and their tutors and consultants will have to try to ensure that they do so.

In this Region, and perhaps in others, District General Hospital psychiatric training posts giving good and varied experience in that setting seem to be finding it increasingly tough to get approval because they do not provide every bit of the desired three-year (plus) programme envisaged by the College's Approval teams, who are seemingly looking for large mental hospital links. All of these concerns have been brought more sharply into focus by the Short Report and the suggestion that if a junior post loses recognition for training purposes it should be terminated by the Health Authority.

Psychiatric posts losing recognition in this way will also be lost to GP vocational training schemes, although they have been deemed to be highly relevant to further GP's needs.

I found it easy when a Senior Lecturer in a University Department with a large pool of registrars to organize a rotation scheme for them, but even there some attachments

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for child psychiatry and psychotherapy were on a sessional basis, not as a full-time attachment.

No one is going to offer any psychiatry tutor working in a District General Hospital another registrar's post to ensure ample numbers so as to give full six-month placements in all desirable settings.

We are going to have to try and ensure comprehensive training by attachments on a sessional basis to as many areas of psychiatric interest as is possible.

The College's demands for a fixed stereotyped three-year training programme is making our tasks very difficult, and we risk not being approved with posts losing recognition, just as a Local Elderly Mentally Infirm Unit is set up sixty miles from the nearest mental hospital, and fifty miles from the nearest psychogeriatrician.

Can the College not think afresh about the training of psychiatric junior staff in District General Hospitals Units, and would they not consider limited or partial approval for two years in such a setting where there is no mental hospital handy to complete the desirable three-year experience? Might posts not be approved, as in other specialties, rather than full programmes?

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College recognition of psychiatric tutors

DEAR SIR

The principles and criteria recently approved by Council (*Bulletin,* February 1982, **6,** 24) for the recognition of psychiatric tutors are welcome, but there are areas to which the College should give further thought:

1. In order that the interests of the majority of psychiatric patients are not disadvantaged, should there not also be a psychiatric tutor (specialty) in general adult psychiatry?
2. If the reports on trainees which the tutor is expected to prepare are of a written nature this should be indicated in the Statement on Approval which is sent to hospitals before Approval visits. Tutors and Approval Exercise Visitors in the past have disagreed on the practical interpretation of the present wording—that the tutor is 'responsible for collating the periodic assessment reports on trainees'. Many tutors and Approval Teams would also welcome comment from the College as to the form such reports should take.
3. Is not the amount of time to be allocated to the tutor best left for individual Divisions of Psychiatry to decide, on the basis of local arrangements and conditions? The document does acknowledge that tutorial duties vary between Regions but nevertheless states that 'a minimum of two sessions per week' should be allocated for tutorial duties. With consultants keen to participate in teaching and well motivated trainees, two sessions per week, for duties which are mostly of an organized nature, may seem unduly generous, particularly at times when there is any difficulty in meeting routine service commitments. In such circumstances there will be a natural increasing tendency to off-load teaching responsibilities on to the tutor because of his specific allocation of time for such. This would narrow the breadth of teaching experience to which trainees would be exposed.

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The College and South Africa

DEAR SIR

Dr Hemphill (*Bulletin,* March 1982, **6,** 44), like other white psychiatrists in South Africa before him (Gillis, 1977), chooses to ignore the main body of evidence in support of allegations of political abuses in the field of mental health there. Most of the evidence for political misuse of psychiatry in South Africa was summarized in my letter (*Bulletin,* November 1980, 171), and this was based on reports published by the World Health Organisation and the American Psychiatric Association. Apart from his ritual protestations, Dr Hemphill's attempt to discredit my motives and doubt the credibility of the accusations is not supported by any new facts.

His claim that South African mental health legislation is free of discriminatory provisions is irrelevant. It is also misleading, because he fails to mention that the apartheid system, under which all South African laws are enacted, is based on direct discrimination on the basis of skin colour alone. His suggestion that abuses do not exist because no one is authorized to misuse psychiatry is as credible as denying political bias in Soviet psychiatry because there are no laws in the Soviet Union which specifically invest psychiatrists with additional responsibilities to detain political dissenters in mental institutions. Dr Hemphill's naïve belief that practice of psychiatry, or for that matter medicine, could be free of prevailing social and political considerations can only be attributed to a refusal to recognize the realties of the apartheid system.

I referred to an article in the *Johannesburg Sunday Times* entitled 'Millions out of Madness' (27 April, 1975) because this was one of the first reports to accuse the minority government of a profit-incentive business deal with a private accountancy film, Smith, Mitchell and Company, which led to sub-standard care for black psychiatric patients. Miss de Villiers described the appalling conditions in mental institutions for blacks as 'a South African version of the Dickensian workhouse, an uncomfortable reminder of the bad days in Bedlam . . .'

If Dr Hemphill really believes that there is no differentiation in the standards of psychiatric care according to the

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