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Reciprocal training in old age psychiatry and geriatric medicine in South Gwent

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Skill in physical medicine is an often neglected area in psychiatric training. It is nonetheless very important, particularly in the care of the elderly. The need for reciprocal training in geriatric medicine and old age psychiatry was highlighted in *Care of Elderly People with Mental Illness* (1989), the Joint Report of the Royal College of Physicians and the Royal College of Psychiatrists on services for the elderly and medical training. It recommends that, "Higher professional training for specialisation in the psychiatry of old age should include at least two months experience in geriatric medicine", and suggests that this previously optional experience should become an obligatory part of specialist training. It indicates the alternative ways of gaining such experience: a short secondment, a weekly sessional commitment or a direct exchange of posts.

A survey by geriatric senior registrars reported in *Reciprocal Training Schemes for Senior Registrars in Geriatric Medicine and Psychiatry of Old Age* (1990) (a discussion document for the Joint Liaison Committee of the British Geriatrics Society and the Royal College of Psychiatrists) showed wide variation in practice ranging from no opportunity to a six month secondment. Opinion was, however, almost unanimous (103 out of 104 geriatric senior registrars) that some experience in old age psychiatry was important. Current practice is being surveyed by the old age psychiatry senior registrar group.

The South Gwent geriatric and old age psychiatry departments share a building for acute patients, short-term rehabilitation and the geriatric day hospital. Although they are not fully integrated and do not, for example, operate joint ward rounds, there is exchange at the level of liaison referrals and management. In South Gwent we opted to make a two month direct exchange between the departments a formal part of the old age psychiatry senior registrar slot. We decided not to swap on call duties because lack of expertise would not enable these roles to be filled properly. With research and special interest sessions elsewhere the direct swap amounted to six sessions a week.

Expectations

There was some similarity in our expectations. We expected to gain clinical experience, in functional illness for the geriatrician and in general medicine for the psychiatrist, and to learn about differences in discharge policies and in community services. We also hoped to be exposed to management issues. Our levels of anxiety were quite different as the geriatrician had previously worked as an SHO in psychiatry and felt more comfortable in this area while the psychiatrist felt that his medical skills were sub-optimal.

Experience

The geriatrician joined weekly acute ward rounds, multidisciplinary and management meetings. He had direct responsibility for one long-stay ward and the travelling day hospital with consultant back-up on the phone. The psychiatrist joined acute and rehabilitation ward rounds with the consultant, out-patient clinics with a consultant available next door, and a weekly Parkinson's disease out-patient clinic. Both SRs took the opportunity to see the various facilities available. A flavour of on-call work was achieved by the geriatrician doing some urgent domiciliary visits and by the psychiatrist assessing Accident and Emergency and other ward referrals.

The geriatric job was exclusively hospital based in contrast to the psychiatry job which had a large community component. The former generated much less anxiety than feared, perhaps because less responsibility was given than had been anticipated. A lot of general medicine was relearned, though again, less than expected. It was possible to get experience of admission and discharge policies, although not in the context of the whole service because of the emphasis on in-patient care. The psychiatry job generated less work with the functionally ill and also carried less responsbility than expected.

Views of others

Staff, both medical and non-medical, had difficulty understanding our changed roles. The junior medical

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staff tended to by-pass us, while the consultants found it hard delegating responsibility to the senior registrar.

Nursing staff had particular difficulty in understanding our roles. The geriatric nurses tried to provide the psychiatrist with numerous psychiatric problems to manage, and the psychiatric nurses seemed to think that the swap was permanent and worked to involve the geriatric senior registrar in long-term planning. Physiotherapists and occupational therapists were very helpful in providing relevant information.

Disclosure to patients and carers of the details of the exchange was not discussed beforehand and we did not have an agreed policy. Some patients and carers were briefed but others, because of pressure of time or sensitivity issues, were not. In general, psychiatric and acute medical patients were not briefed. In more relaxed settings such as the Parkinson's disease clinic most patients were told and they often took the opportunity to discuss psychological problems. This occurred to a lesser extent in the geriatric out-patient clinics.

Changes in practice

There were some changes in practice after the swap. The psychiatrist continued to join in the geriatricians' ward round which was perceived as being extremely helpful by the nursing staff. Also, one of the old age psychiatry consultants has now changed his out-patient clinic to coincide with the geriatric out-patient clinic. The geriatrician feels he now gives increased priority to the symptoms of functional illness in his patients.

Conclusions

Some deficiencies in our exchange were highlighted and could be improved by the following recommendations.

(a) Extensive briefing of all medical and non-medical staff should take place beforehand.
(b) Community experience in the geriatric job should be included.
(c) Details of the exchange should be disclosed to all patients and carers.
(d) Consultants should work towards increased delegation of responsibility.

The swap was, however, considered worthwhile by all involved. It may not deserve the title of a "direct exchange of posts" because only six sessions per week were used and there was not a straight swap of all senior registrar responsibilities. However, not only did the senior registrars gain, but there was also a general feeling that the exchange improved working relationships between the two departments.

References

Care of Elderly People with Mental Illness – Specialist Services and Medical Training (1989) A Joint Report of the Royal College of Physicians and the Royal College of Psychiatrists.

Reciprocal Training Schemes for Senior Registrars in Geriatric Medicine and Psychiatry of Old Age: A Discussion Document for the Joint Liaison Committee of the British Geriatrics Society and the Royal College of Psychiatrists (1990) BGS/RCPsych Liaison Committee.

The Transcultural Psychiatry (Special) Interest Group

The Transcultural Psychiatry (Special) Interest Group had its inaugural meeting at the Spring Quarterly Meeting in Dundee. Dr Parimala Moodley was elected as Chairperson. There will be a business meeting of this group during the Autumn Quarterly Meeting in Birmingham. All interested members are invited to attend. Members wishing to join the group are asked to send their names to Mrs Jean Wales at the College.

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