EDITORIAL
'Back to basics': on not neglecting the elementary in continuing professional development

Andrew Sims

The scope and significance of, and involvement in, continuing professional development (CPD) have grown in medicine and specifically in psychiatry over the past 10 years; that is, since what is now called *Advances in Psychiatric Treatment* (*APT*) was the germ of an idea in the mind of Professor Greg Wilkinson, then the newly appointed editor of the *British Journal of Psychiatry*. Over this decade, there have been 'push' factors towards CPD from the Department of Health, the General Medical Council, increasing litigation against doctors and lobbying by the general public. More important, however, have been 'pull' factors within the profession. Moderate finance has been earmarked for CPD and most doctors have welcomed with some enthusiasm the possibility of dedicated time, involvement with their peers and the opportunity to attend conferences, workshops and case discussions. The uptake was already good even before it became virtually compulsory.

The content of CPD in psychiatry has been under constant scrutiny and the obvious conclusion has been reached – that each psychiatrist requires an individual programme of further education. Hence the development of a personal plan. Early on, the Royal College of Psychiatrists stated its intention to pursue continuing professional development rather than continuing medical education, thus expressing the intention of helping consultant psychiatrists prepare and maintain themselves for all aspects of running a clinical service in psychiatry rather than only concentrating narrowly on recent advances in medicine.

There is a potential problem with the scheme of CPD that we have devised and it might be described as 'the track-laying dilemma'. When a new surface or gauge is laid down, the old has to be removed and the best track-laying machine will carry out both operations at the same time. However, it is important with continuing medical education that as the mature, and possibly ageing, consultant acquires new knowledge and skills, he or she does not lose basic medical skills. As practitioners, we continue to need to use what we learned at the beginning of our psychiatric, and even medical, training.

Let me illustrate this point with three cautionary tales. In the first of these, I am the patient and therefore there is no problem with confidentiality. In the subsequent two, some details have been altered.

Case vignette 1

In February 1999, I was admitted to hospital for routine hip replacement following osteoarthritis of the right hip which I had first noticed and diagnosed when ascending Mount Kosciusko in Australia, 10 years before. In going through the routine admission procedure, I was examined by a courteous and eager pre-registration house surgeon, with 7 months' experience as a qualified doctor. I told him that in my 20 years in Leeds I had not had a day's illness. He examined me carefully and when he palpated the left side of my chest with his fingertips and put his stethoscope to my neck, I was surprised and impressed.

Within the hour, I was having an echocardiogram which showed a pressure differential of more than 100 mm of mercury across the aortic valve. I was taken off the operating list for the next morning, ignominiously sent home and then readmitted to cardiac surgery a few weeks later for aortic valve replacement. It is not overdramatic to conclude that my life was preserved by an alert, well-trained house surgeon performing his basic medical skills.

Would I have spotted aortic stenosis in a patient I examined before giving electroconvulsive therapy?

Case vignette 2

A female patient, aged 67, was admitted to hospital with severe depressive illness. She was examined

Andrew Sims was Editor of *Advances in Psychiatric Treatment* from 1993 to 2002. He is a past-President of the Royal College of Psychiatrists (1990–1993) and is Emeritus Professor of Psychiatry in the University of Leeds (Clinical Sciences Building, St James's University Hospital, Leeds LS9 7TF, UK).

https://doi.org/10.1192/apt.9.1.1 Published online by Cambridge University Press

physically by the psychiatric registrar and nothing abnormal was found. A competent examination of mental state was also performed. A couple of days later, the consultant saw her and prescribed electroconvulsive therapy. However, before treatment could be given she became comatose. She was transferred to a medical ward, where she died within 24 hours.

She was not known previously to have been diabetic, but the cause of her coma was hyperglycaemia. Her psychiatric examination and management in hospital had been impeccable and the initial physical examination appeared to have been thorough. But the simple ward routine of testing a sample of urine for sugar on admission had been omitted and for that reason alone, severe diabetes of recent onset had been missed.

Are you sure that all your new admissions to psychiatric in-patient care have had their urine tested routinely for sugar?

Case vignette 3

A man, aged 28, was admitted to a psychiatric ward. Five months previously, in an attempted murder, he had been shot at close range. Despite heavy bleeding from his arm, he had escaped in his car and obtained emergency treatment from the nearest hospital. Since the incident, he had suffered from severe psychological symptoms and, independently, two consultant psychiatrists had made the diagnoses of depressive illness and post-traumatic stress disorder.

After a few weeks, when he was told of the decision to discharge him from in-patient care, he became very upset indeed and a fracas broke out in which he and a charge nurse accused each other of a physical assault. At the time, he was under the care of a locum consultant, who came onto the ward shortly afterwards, changed his diagnosis to aggressive psychopathy and peremptorily discharged him.

That diagnosis hung around him like an albatross, blighting his subsequent attempts to obtain psychiatric treatment and ruining his relationship with every health professional he met. Within his own National Health Service (NHS) health district, several health professionals from different professions, when approached by his general practitioner, stated that neither they, as individuals, nor the district had the facilities to treat patients with dissocial personality disorder (as in ICD–10; World Health Organization, 1992). When he sought treatment outside the district, the authorities refused NHS extra-contractual referral on the grounds that facilities were available, and he must obtain treatment, within the district. As a result, despite being at high risk of suicide, he was unable to receive specialist psychiatric treatment for many months and he totally lost confidence in all doctors, especially psychiatrists.

Psychiatrists should beware. The diagnoses that we wield may be blunt instruments, but they are very powerful and the consequences are extensive and long-lasting. Whatever the motivation for the arbitrary change of diagnosis, it was a grave error of judgement and resulted in long-term harm to the patient.

Of course, CPD should be concerned with innovations in treatment, with sophisticated refinements to our therapeutic armamentarium and with recent developments in the natural and social sciences which make a significant contribution to our clinical practice. But we must also preserve the basic knowledge, attitudes and skills of our profession. I have deliberately emphasised physical aspects of psychiatric care because they are in most danger of neglect. Alongside our CPD, we need to retain the fundamentals and good clinical judgement in caring for our patients, combining respect for them as individuals and basic, informed common sense.

This Editorial is intended as a 'signing-off' from my post as Editor of *APT*. It has been an exhilarating experience to grow the journal from seed and it now has a respected place among psychiatric journals, with an impressive number of subscribers. I would not have been able to achieve anything without the professionalism and dedication of Louise Whalley and Gillian Blease as successive editorial assistants, all the excellent and hard-working members of the Editorial Board, and Alan Lee, initially as Deputy Editor and, for the past year, Co-editor. Professor Wilkinson and the staff of the Publications Department of the College have given unstinting support.

Continuing professional development started as a 'Cinderella' in psychiatric education alongside undergraduate medical teaching and postgraduate training of future psychiatrists. It has now become a princess in its own right and *APT* has had to develop to keep pace with this. *APT* has always had a comprehensive view of the professional development of trained psychiatrists and I am sure that, under Alan Lee's able leadership, this will continue. Comment and constructive criticism from the readership is always of inestimable value.

References

World Health Organization (1992) *The ICD–10 Classification of Mental and Behavioural Disorders. Clinical Descriptions and Diagnostic Guidelines*. Geneva: WHO.

https://doi.org/10.1192/apt.9.1.1 Published online by Cambridge University Press