

Trainees Forum

Training Perspectives in Two Neighbouring Rotational Schemes in Psychiatry

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This paper aims to compare two SHO/registrars training schemes, both of which have grade 'A' approval from the Royal College of Psychiatrists but have differences in character and content. We intend to present an overview of current general training in psychiatry by focusing on these rotations. We would like to point out that these are personal views based on our own experiences, but hope that this paper will stimulate discussion.

One of the rotations we consider is based at a regional teaching centre while the other is based in a hospital serving a peripheral district. For simplicity we will refer to these as the Teaching Hospital and the District Hospital rotations. The comparison will be in three parts: first a consideration of the basic physical structure of each rotation, second, a discussion on the relationship between this structure and the trainees within it, and third, some comments on how these differences may affect career prospects.

The Teaching Hospital rotation is well established and has grown in size, and therefore organisation, since it began. There are currently 27 full-time posts on the rotation which change at six monthly intervals, the scheme lasting for three and a half years. All but six trainees are based at or near the two central hospitals and nearly all the clinical firms have senior registrars attached. Supervision may also be provided by lecturers or research psychiatrists from the University Department.

The District Hospital rotation was established more recently, initially in 1980 and operational at six monthly intervals in 1983. There are 11 full-time SHO/registrars including two GP trainees. One senior registrar is attached to the hospital from the Teaching Hospital higher training rotation. SHO/registrars work closely with their consultants to form the basic unit of medical input. This rotation also lasts for three and a half years.

Clinical responsibilities

Opportunities for gaining clinical experience differ little between the rotations at a fundamental level. Both provide experience in adult general psychiatry, psychogeriatrics, psychotherapy, day hospital and out-patient work. The placement in mental handicap and a portion of the placement in child and adolescent psychiatry are based at the same hospital in each rotation. Both schemes contain a

therapeutic community placement and the Teaching Hospital rotation offers full-time posts in liaison psychiatry and in the management of alcohol dependence. Experience in the latter two fields is gained on a sessional basis throughout training at the District Hospital.

On call duties differ little, a fairly constant one in nine at the District Hospital while the large size of the other rotation means that on call duties are split into more manageable units on a geographical basis. Commitment varies from one in three to one in nine. The geography of the two areas also leads to differences in admission procedures. The District Hospital is situated near to the edge of its catchment area in a rural setting, resulting in patients being accepted for admission rather than for assessment. An assessment procedure is used in the admission units of the Teaching Hospital rotation, this being facilitated by their situation close to urban districts. Thus inappropriate admissions are more easily avoided in the larger setting, while in the District Hospital some patients may be admitted overnight only to be discharged the following day.

On call senior cover is readily available in both settings, provided by senior registrars and consultants. Trainees in the smaller rotation have direct contact with consultant staff while those in the teaching rotation usually communicate with senior registrars.

It is difficult to compare exactly the day to day workloads of trainees on the two rotations but it is fair to say that there are noticeable differences. On the whole, the Teaching Hospital rotation has a higher staff to patient ratio, particularly if medical students are included. Trainees in the smaller rotation may, therefore, expect to see more cases, especially in the adult attachments. Partly because of this, but also because of the expectations of the rotation, the depth of enquiry into all aspects of the cases, whether social, physical or academic, is not as great as that achieved in the Teaching Hospital rotation. This will surprise few, indeed many will have noticed this disparity during their own training. However, both systems give the trainee comprehensive experience and instil clinical confidence.

The different staffing ratios mean that more day to day management decisions are taken by the trainee in the District Hospital while decision making by pre-planning is more typical of the Teaching Hospital.

The peer group

In psychiatry, more than in other medical specialties, doctors need to be part of a supportive peer group. In the district hospital it is obvious where this peer group is centred. There is one main building and from this all services emanate. This results in a strong sense of union among the junior medical staff. There is one common room and one junior mess. In the larger rotation arrangements are less centralised. There are more trainees, more parts of the rotation, more buildings and more doctors of other grades to accommodate. This can lead to a degree of isolation from colleagues and makes mess activities less intimate and more difficult to organise. Twenty-six peers are a lot to get to know. For similar reasons, accurate representation of majority views on hospital committees is more difficult to achieve in the larger scheme. In the District Hospital rotation the political structure is less complex and opinion more readily canvassed. Similarly, hierarchies are more easily identified and problem solving tends to be speedier, more straightforward, and informal.

Peer groups are difficult to characterise as they are composed of individuals. There is no doubt that the individuals on each scheme influence the whole but the converse is also true. As described above, the Teaching Hospital group of trainees is larger and less intimate. Here the trainees tend to have more experience in other fields prior to beginning a career in psychiatry. They tend therefore to be a few years older than the District Hospital trainees. The ethos at the Teaching Hospital is heavily influenced by the academic standards of the University department, and this leads to an undercurrent of friendly competitiveness. In comparison, the trainees at the District Hospital are a more disparate group, a mixture of career psychiatrists from the UK and overseas, and GP trainees.

Personal tutelage

This is an important aspect of every training scheme and operates primarily through personal tutors. In the smaller rotation, frequent contact with tutors is maintained informally day to day in the hospital building. Again, the size of the Teaching Hospital organisation means that meetings are less frequent and probably more formal as a consequence. These differences do not necessarily alter the number of scheduled meetings but do perhaps change their quality.

One aspect of the tutor's role is the organisation of the trainee's individual rotation. The Teaching Hospital aims to settle this provisionally in the first six months. The less structured format of the peripheral hospital allows more informal arrangements to be made, but fewer posts in any one subspeciality, and the need to give those training for only a short period appropriate general experience, means that opportunities must be taken as they arise. Consequently, the needs of the trainee are somehow fitted in with the needs of the service. Flexibility is possible in both schemes but it would seem that this is more difficult to administrate in the larger rotation.

Teaching

Both rotations share the same MRCPsych course which takes place at the Teaching Hospital. Other lectures and seminars here are open to trainees from the District Hospital but work commitments and travelling distances often make attendance difficult. This regular flow of guest and research-based lectures sometimes seems to occur at a tantalising distance for the District Hospital trainees.

Both schemes run internal training in the form of lectures and seminars given by outside speakers or the trainees themselves. Self-teaching groups flourish in both hospitals prior to examinations but the academic milieu of the larger rotation tends to aid this process and provide a ready source of teachers.

Research

Involvement in research is becoming increasingly important for all trainees and here the larger rotation is fortunate in offering the possibility of a full-time, six month, externally funded research post. In addition, prolific research units in the area influence and stimulate ideas for research projects and may provide opportunities for collaboration. The District Hospital does not have these facilities to hand in such profusion, and in the past advice pertaining to research was generally sought at the Regional centre. More recently, however, trainees have begun to group themselves into units to devise topics for research.

Career prospects

Both rotations have no difficulty in producing successful candidates in the Membership examination. Several factors, however, have a bearing on the progress of the trainee to higher psychiatric training. This progression seems to be more readily effected from the Teaching Hospital rotation for the following reasons. Trainees selected for the Teaching Hospital rotation tend to have more post-graduate qualifications than their District Hospital counterparts and they have received their training in association with a respected academic department in a leading university. They are thus familiar with a Regional centre, and, by the end of their training, they have been fully assessed by their tutors in this centre. They have therefore an enviable relationship with the Regional centre for higher training. The opportunity to undertake research, as mentioned above, is often looked upon with favour by appointments committees. Given the current scarcity of senior registrar posts in relation to demand, trainees on the District Hospital rotation may find it difficult to compete with such candidates, although their merit as clinical psychiatrists may differ little.

Discussion with trainees from other Regions leads us to suspect that some of the points raised here may be applicable in general terms to other parts of the country.

Comments

It appears to us that, though both rotations set out to provide comprehensive training in psychiatry, they inevitably emphasise different aspects of training. This is largely due

to differences in size, geography, resources, and political structure of each rotation.

From the points made above it becomes clear that the Teaching Hospital benefits from centralised regional resources and a thriving university department. A large field of applicants is attracted when posts are advertised and appointments committees can afford to be selective. The training provides opportunities for research, and academic work is encouraged, not least by a well motivated peer group. Such a rotation produces a well qualified candidate for higher training, and career prospects are good.

The District Hospital does not have on-site access to comparable facilities and, as a probable result, appointments committees do not enjoy so wide a choice. These factors could be seen to promote a two tier training structure which would be self perpetuating.

The central function of each training scheme is, however, concerned with training doctors for consultant careers in psychiatry. As has been pointed out, clinical training differs in style but resulting clinical competence is comparable. The Teaching Hospital rotation undoubtedly provides an excellent training for academic psychiatrists and for consultants

closely linked with academic centres. These posts are, however, in the minority nationally, most consultants being based in District Hospitals. It could be argued that, as things stand, the clinical training acquired in the district rotation provides better preparation for consultants in District Hospitals who carry out the bulk of clinical psychiatry in the NHS. Those who have trained exclusively in academic units could find themselves disorientated on gaining a District consultant appointment.

It appears to us that all trainees would benefit from experience in both types of rotation. At present, many Teaching Hospital rotations do include posts which rotate through District Hospitals. There are, however, fewer District Hospital rotations with fixed posts in academic centres. It could well be that the training of future consultant psychiatrists would be improved by more overlap between different types of rotations and this would also effectively reduce the gap created by the present two tiered structure.

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New Appointments

Oxford Regional Health Authority

- Dr J. S. Harding, Consultant Psychiatrist with Special Responsibility for the Psychiatry of Old Age, East Berkshire, 1 February 1987.
 Dr J. B. P. Brockless, Consultant in Child and Adolescent Psychiatry, East Berkshire, 14 September 1987.
 Dr H. Bullard, Consultant in Forensic Psychiatry, West Berkshire, 1 October 1987.
 Dr E. M. Spalding, Consultant Psychiatrist with Responsibility in Mental Handicap, High Wycombe, 21 September 1987.

South Western Regional Health Authority

- Dr T. F. Packer, Consultant Psychiatrist with a Commitment to Community Care, Exeter, 17 February 1987.
 Dr M. Missen, Consultant in Mental Illness with a Special Interest in the Elderly, Cheltenham, 23 March 1987.
 Dr A. K. Darwish, Consultant in Child and Adolescent Psychiatry, North Devon, 10 June 1987.

Yorkshire Regional Health Authority

- Dr R. J. Williams, Consultant in Child and Adolescent Psychiatry, Scarborough, 28 May 1987.
 Dr M. E. Jenkins, Consultant in Child and Adolescent Psychiatry, Northallerton, 25 June 1987.
 Dr A. Wade, Consultant in Child and Adolescent Psychiatry, East Yorkshire and Hull, 25 June 1987.
 Dr B. C. Chaparala, Consultant in General Psychiatry with Special Responsibility for Psychogeriatrics, Scunthorpe, 25 June 1987.
 Dr B. T. Saleh, Consultant in Mental Illness, Scunthorpe, 25 June 1987.
 Dr A. K. Chaudhary, Consultant in Mental Illness, with one year's secondment to Leeds University, Scunthorpe, 25 June 1987.
 Dr C. J. Simpson, Consultant in Mental Illness, Northallerton, 25 June 1987.

The Editors would welcome information about recent consultant appointments from other Regional Health Authorities.