

in old age psychiatry and wish to consolidate their experience in preparation for ST5. The authors raise the issue of 'functionalisation' of general adult psychiatry and the risk that trainees may have very little exposure to in-patient treatment. That problem is resolved in the new proposals by two specific general adult placements each of 6-months. The new proposals do not equitably consider training issues raised by functionalisation in old age psychiatry.

Old age psychiatry is a multifaceted subspecialty incorporating aspects of psychiatry, physical medicine and neurology. This marries well with the authors' suggestion of incorporating more of these two disciplines in psychiatric training. Offering an older adult placement as a CT2–4 may help to maintain the momentum of focus on these skills, and enhance the expertise of all trainees.

- 1 Oakley C, Jenkinson J, Oyebode F. Psychiatric training for the next generation. *Psychiatrist* 2013; **37**: 25–9.
- 2 Tooke J. *Aspiring to Excellence. Findings and Final Recommendations of the Independent Inquiry into Modernising Medical Careers*. MMC Inquiry, 2008 ([http://mmcinquiry.org.uk/Final\\_8\\_Jan\\_08\\_MMC\\_all.pdf](http://mmcinquiry.org.uk/Final_8_Jan_08_MMC_all.pdf)).

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**Authors' response:** We are encouraged that our paper has sparked some debate of these important issues. We agree with Conn & Husain<sup>1</sup> that conducting emergency assessments out of hours is a crucial component of training in psychiatry. We also support the Section of Neuropsychiatry's view that evaluation of the practical aspects of implementing a more integrated curriculum would be beneficial.

We understand the arguments put forward by Burza & Hilton about the value of old age psychiatry and their assertion that it has non-parity with other specialties in our proposed scheme for postgraduate training in psychiatry. It was not our active intention to reduce trainees' exposure to old age psychiatry but this was a product of the challenge of trying to accommodate neurology, psychopharmacology and psychotherapy which currently are not routine placements. However, we intend our paper to stimulate discussion and would hope that this, and other perspectives, could lead to further shaping of a proposal for psychiatric training for the next generation.

- 1 Conn R, Husain M. Trainees want to work out of hours! *Psychiatrist* 2013; **37**: 117.

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### A meeting point for neurology and psychiatry?

Oakley *et al*<sup>1</sup> highlight an important training gap in the current curricula of both psychiatrists and neurologists. Among other interesting considerations, the article proposes that 'in the first

year of training, a 4-month placement in neurology becomes an integral part of core training [ . . . ] to consolidate clinical examination skills and provide experience in the interface between neurological and psychiatric disorders'.

Historically, there is a tradition of cross-fertilisation between neurology and psychiatry, exemplified by the recent renaissance of the 'bridge' disciplines, neuropsychiatry and behavioural neurology.<sup>2–4</sup> Standards of clinical practice and applied research have benefitted from specialists trained in the assessment and management of behavioural symptoms resulting from pathologies of the central nervous system. In some countries, including the USA and Germany, the opportunity of exploiting these reciprocal benefits is already formalised with integrated curricula at postgraduate training level.<sup>2</sup>

In the UK, compared with their predecessors, psychiatry trainees have fewer opportunities to gain neurological and medical experience before specialisation. It has become increasingly difficult to move between specialties and there is little incentive for trainees to attain MRCP qualification. Over the past few years, the evolving discipline of neuropsychiatry has made some initial steps to bridge this gap.<sup>3,4</sup>

Based on these observations, the Royal College of Psychiatrists' Section of Neuropsychiatry agrees with the direction of the proposal by Oakley *et al* and encourages further discussion to translate valuable principles into practice. From the psychiatry trainee's perspective, achieving the College's core competencies (including working with patients with cognitive difficulties, neurodegenerative conditions) would be greatly facilitated by formal exposure to placements in neurology. The increasing necessity to optimise allocation and utilisation of healthcare resources would favour a revised curriculum, where the psychiatry trainee is provided with opportunities to learn about underlying neurological changes in traumatic brain injury, epilepsy or movement disorders. Trainees could also acquire the ability to diagnose conversion disorder based on physical signs (DSM-5).

Equally, care pathways which are currently far from efficient or cost-effective could be streamlined if the neurology trainee received exposure to the principles of conversion disorders and common behavioural symptoms and their management.<sup>5</sup>

Finally, we feel that the same principles should apply to colleagues dealing with neurodevelopmental conditions, where formal training of child and adolescent psychiatrists would benefit from incorporating core elements of the paediatric neurologists' curriculum. In other countries (e.g. Australia, New Zealand) additional training in paediatrics and neurology is available through dual training programmes and additional certifications.

It is important that we examine psychiatric workforce development needs in the context of advances in neurosciences research and our developing knowledge of brain functions and brain disorders. The members of the Section of Neuropsychiatry express their wish that the proposal for a more integrated curriculum gains priority in the agenda of postgraduate educational committees, where the practical aspects of its implementation should be evaluated in the light of economical and logistical implications.