Foreign Report

Comments from Canada

By William O. McCormick, Toronto

The Editors of the *Bulletin* have invited me to be an occasional contributor with news from the Canadian psychiatric scene. 1980 could be described as 'The Year of the Presidents'. In the early summer we had Sir Martin Roth and Professor Linford Rees not only both in Canada at the same time, but their paths actually crossed in the same Toronto hotel. While the first and second Presidents of the Royal College were travelling in different directions, we in Toronto were privileged to have both of them speak at different gatherings in the same week. In September, Professor Pond was whisked around Ontario giving several papers before being allowed to relax as the College's official representative at the Canadian Psychiatric Association annual meeting, also in Toronto.

During this 'jamboree', the President attended a meeting of the North American branch of the Royal College, and during this meeting the question of reciprocity between specialist qualifications in the British Isles and Canada, amongst other places, was discussed. Later I had some conversation with the President and he encouraged me to send in the following despite the fact that it is not truly a 'Canadian' comment.

Let's reform the College

I toyed with the idea of sending these suggestions five years ago, when I first discussed them with the then Editor of the *Journal,* Dr Edward Hare. I feared that they might be seen as emanating from a sickly brain about to drain. They had their basis in observations on Council, the Education Committee, the Psychiatric Tutors Committee and the Joint Committee on Higher Psychiatric Training during the early years when Sir Martin had to steer the ship through some fairly stormy seas.

The problems

The basis for my suggestions requires the acceptance of some axioms.

1. It is certainly possible to be pleased and gratified to be elected to the Fellowship from the Membership; it follows that it must be possible to be 'miffed' or disappointed not to be so elected.
2. In the years just before and ever since the Royal College was founded there have been considerable hassles* about appropriate representation on committees and Council of trainees in psychiatry.
3. There have been many criticisms of the MRCPsych examination, amongst which is the fact that it falls between two stools: it is neither a screening 'entry' examination comparable to the MRCP (UK) nor an 'exit' examination on the completion of specialty training comparable to MRCPath.
4. There has been concern about the lack of equivalence of the MRCPsych to specialist certification in the EEC. This lack of reciprocity has also been discussed in connection with Canada and the USA.

It is obvious that we cannot expect to regard an examination which can be taken after only two years of psychiatric training as a full specialist qualification. MRCPsych can be taken with only two years of actual psychiatry, if appropriate credit for previous post-registration training in other medical fields has been granted. In the Education Committee and Council I was a vigorous supporter of the granting of credit for alternative training but that was towards the taking of an examination, not towards being regarded as a fully trained specialist.

5. The DPM qualifications have been defended as fulfilling a need for some doctors who will not proceed to full psychiatric specialization. They have been criticized because, of 22 DPM's at one time offered in the British Isles, very few were associated with close monitoring of the training required before taking the examination.
6. My final axiom suggests that our sister College, the Royal College of Surgeons in England has not seemed to suffer loss of face or dignity by allowing the Fellowship to be acquired on completion of the basic surgical specialist examination or, indeed, by allowing Membership of their College—complete with the sporting of their tie—to be acquired by new medical graduates who happen to take the Conjoint qualifying examination.

The solution

1. The preliminary test for MRCPsych should be replaced by the MRCPsych examination to be taken after appropriate training of some one to two years. I would not presume to fix the exact time. I would like to see the sciences-basic-to-psychiatry components strengthened as compared with the preliminary test. There would be a significant, although not searching, test in clinical psychiatry as well.

The recipient of the MRCPsych would be in a position to proceed to full specilist training, or to practise in other branches such as general practice with recognition of his psychiatric grounding (comparable to DCH or DRCOG).

2. After a time appropriate for full specialist training (four to five years—to be discussed) an exit screening procedure

*(My Irish-based brother assures me that 'hassles' is a word now in the British Isles vocabulary.)

https://doi.org/10.1192/S0140078900014826 Published online by Cambridge University Press

would be used to confer full specialist status and the FRCPsych qualification.

Nobody will be hurt any more by being overlooked for the Fellowship. The present Bye-law structure, without need for further reference to the Privy Council, will provide us with senior trainees on all important committees and we shall have a reasonably lengthy specialist training with which to start to negotiate reciprocity with some other countries.

I have carefully avoided going into the question of the form of the examination with which to 'exit' into FRCPsych and glory. As a final, genuinely Canadian comment I should say that the FRCP(C) examination in psychiatry is under considerable criticism. Perhaps the time is ripe for a pleasant collaborative conference between representatives of our Colleges in a suitable location equipped with para-conference facilities. Either Nova Scotia or Newfoundland would be more or less equidistant between London and Central Canada; they are scenically gorgeous and the sailing and fishing rival Ireland or Scotland.

Child and Family Psychiatry: Planning for Survival

By Michael Black and Jean Harris
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If Child Psychiatric Services are to survive into the 1980s, we believe that practitioners will have no alternative but to make sense of the complicated administrative network on which their future depends. This is an account of one such attempt by three Child and Family Psychiatric teams working in a Health Authority Area.

In an earlier paper[1] we described how one local authority met the recommendations of a Joint Circular[2] which asked for the formation of interdisciplinary working parties to report on the future provision and organization of child guidance via Joint Consultative Committees to the Department of Health and Social Security and the Department of Education and Science by December 1976.

The Bedfordshire Joint Consultative Committee report of March 1977 stressed that the Child and Family Psychiatric Service (formerly the Child Guidance Service) should be represented on relevant planning teams, and noted the Joint Circular's recommendation that Joint Consultative Committees should keep under review agreed arrangements between authorities for the maintenance of child guidance services.

After the relevant reports had been accepted, the former Child Guidance Study Group was reconvened to discuss future policy; this was undertaken by specialists in community medicine (Child Health and Social Services). They called together representatives of the child guidance network, including the new separately administered Education Psychological Service, and the Child and Family Psychiatric Service (jointly staffed by the National Health Service and the Department of Social Services).

Two complementary study groups were created, with members in common, each with access to appropriate sub-committees of the Area-based Joint Care Planning Team and thence to the Joint Consultative Committee.

1. *Interface Group*

To be chaired in rotation by Social Services and Education Department administrators and Community Physicians: its brief to clarify the complementary and at times overlapping roles of specialist resources within the network of services for children and their families. Because the Education Psychological Service had become a separate one, this was the only forum in which joint planning could take place between the Education Department, the Education Psychological Service and the Child and Family Psychiatric Service.

2. *The Child and Family Psychiatric Service Joint Planning Group*

Social Service administrators, Community Physicians and practitioners* agreed (i) to act as a planning group able to make recommendations to the Mental Illness Sub-committee of the Joint Care Planning Team; (ii) to monitor the Child and Family Psychiatric Service on behalf of the Area Health Authority and the Department of Social Services.

These arrangements were made so that the Interface Group could tackle the necessary but often acrimonious interagency battle about the use of current resources, while the planning group focused on a more limited yet urgent brief, the maintenance of community-based psychiatric services for children and adolescents during a time of increasing economic stringency.

The planning group agenda included (i) future adolescent psychiatric provision; (ii) emergency responsibilities and (iii) future input of resources. The Community Physicians asked that items (i) and (ii) be dealt with first, and the practitioners subsequently felt that they had made a tactical mistake in agreeing to this request. As a result, although working in a service with no beds, junior doctors or nursing staff, and with switchboards available only from 9 am to 5 pm, they became recipients of community anxieties about self-poisoning

*The practitioners were representatives of the three Child and Planning Psychiatric Service teams, and consisted of psychiatrists, social workers, a child psychotherapist and a play therapist.

https://doi.org/10.1192/S0140078900014826 Published online by Cambridge University Press