*Raising Standards in Psychiatry**

Training at Senior Registrar Level

By Francis H. Creed

The title chosen by the Association of University Teachers of Psychiatry for their meeting was 'Improving Higher Psychiatric Training—Roles and Responsibilities'. This title implies firstly that higher training needs to be improved and secondly that someone must take responsibility for doing so. The Joint Committee on Higher Psychiatric Training officially holds this responsibility, but the AUTP is obviously concerned to critically review the progress so far made.

Much more is heard generally about training at SHO and registrar level (especially in relation to the MRCPsych exam) than about training at senior registrar level. The implications of training at the higher level are obvious but are worth spelling out. Once a trainee is appointed to a senior registrar post he will almost certainly become a consultant, and the better he is trained the better psychiatrist, teacher and influence will he be. Any short cuts here can leave us with a consultant operating at less than optimal level for 30 to 35 years during which time he may be responsible for and therefore influence up to 70 SHO's and registrars.

I believe most trainees are pleased to find that since the term 'higher training' has been recognized the training opportunities for senior registrars have improved. Fortunately there is now something more to higher training than the traditional concept of finding a good boss, being polite to him, filling in for him while he is away without complaining and modelling oneself on his behaviour; but there are still some who tend towards this view and there are some specific problems still to be overcome.

In order to make use of these new opportunities trainees must have adequate time set aside for this purpose, but a frequent complaint even at senior registrar level is that there is insufficient time when they are free of clinical commitments. I understand from trainee representatives on Approval visits that too few centres accept the principle that senior registrars should be, at least for a substantial proportion of their time, supernumerary to the routine clinical work.

Guidance

The second most common complaint is the lack of co-ordination and discussion of these higher training opportunities. Supervision at SHO/registrar stage is frequently discussed, and the Guidelines on Criteria and Facilities for Training published[12] by the Royal College state: 'Continuous assessment of the doctor in training by consultants and tutor through inquiring into and help with areas of weakness is necessary and should eventually benefit both the trainee and *the service*' (my italics).

A study of psychiatric residents in the United States[7] revealed that a close relationship with senior faculty staff was the most valuable aspect of training in the eyes of trainees, as, incidentally did a study of paediatric house officers and residents.[10] Robin Murray and I found in our study of the training of registrars at the Maudsley that 'feedback from the consultant' was an essential factor of good teaching, whether it was academic instruction, practical management or interview skills. However, our recent APIT survey revealed that only a quarter of trainees see their psychiatric tutors to discuss their progress three or more times a year and over half never see their tutor for such a purpose; some even stated that they did not know who their tutor was!

At senior registrar level the nature of the supervision may be different—guidance is a better word—but it is equally essential, in fact even more important, if 'misguided' trainees are not to become consultants.

a) *Rotation:* The organization of a rotation scheme is the best known aspect of this guidance, but it needs to be mentioned that the nature and extent of this rotation should be considered in the light of a senior registrar's past experience as well as his future career plans. Although the latter are obviously important, one of the first tasks of training at the 'higher' level can unfortunately be to correct faults or deficiences of training at the registrar stage. A senior registrar who has not had the opportunity to gain enough personal experience of psychotherapy, for example, should be encouraged to do so even if he tends toward an organic orientation. Indeed, this orientation may simply reflect the lack of opportunity at earlier stages of training.

b) *Clinical:* The transition from registrar to senior registrar occurs in name overnight, but a trainee may require clinical supervision with areas of work that are new to him, such as liaison psychiatry, if he is to reach satisfactory maturity of clinical judgement. But, apart from the direct clinical aspects, help is most often appreciated with the organization of clinical work. A registrar may simply follow a consultant's instructions regarding how the out-patient clinic is run, but a senior registrar may have his own clinical load in this respect and will appreciate help in evolving his own method of working. He can select from the models he observes, but needs to integrate these—some consultants

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continue to care for enormous numbers of out-patients for years, whereas others refer most back to the G.P. Practices similarly vary with referral to psychologists and social workers, and these decisions are new to a young senior registrar. The methods of selecting new out-patients and assessing overdoses introduce similar opportunities for the senior registrar to contribute his own ideas as well as draw on others' experience, but the opportunity to discuss these is vital.

This discussion is best done in a peer group—in which the Professor or Senior Lecturer should be involved. Because of small numbers in any one centre, this peer group support is often missed, but geographical separation need not prevent it—the senior registrars in the West Midlands Region manage to meet regularly even though this involves travelling considerable distances for some. A great strength of my own training has been regular senior registrars' meetings which were primarily concerned with those issues of management, administration and policy which are so important at consultant level but so little taught.

c) *Teaching:* The teaching of medical students is another activity that may well be new to a senior registrar. It is important that he should have time to think about and discuss this and even perhaps engage in some simple educational experiments. There is a tendency in medical education generally to teach in the traditional manner. An American educator wrote recently in the *Journal of Medical Education*[1] that he had been 'distressed to read... that faculty members are teaching as they were taught and not being encouraged to do better'. Because he is fresh to teaching and is nearer in time to his own student days than his consultants, the senior registrar can have many useful ideas which, with help and guidance, may improve the teaching of students and registrars. Such joint ventures by consultants and senior registrars would contrast sharply with the familiar statement: 'Dr X is new so he can do the lecture course this time.'

d) *Research* and private study are often mentioned as part of the senior registrar's training but can only exist if there is time for them to be done properly. Even if time is available, the guidance is so often lacking to get a research project off the ground. Ideally, the seeds of such a project should have been sown at the registrar stage, as should the principles of research, but this may not have happened. A clear role for the university is to provide, if necessary, satisfactory supervision for research even to those senior registrars in their Region who are working in regional hospitals.

Far too often a senior registrar is asked what project he has in mind, and does not have suggestions put to him by an experienced research worker if necessary. More often he should have help with transforming an idea into a viable proposition—which usually involves reducing the ambitions of the keen senior registrar. I don't think many Professors and consultants have any idea how threatening senior registrars find this business of having their proposed research projects torn to pieces. At a time in their career when their clinical competence is reaching a level where they can become consultants, trying to get a research project off the ground is like starting all over again. It is often said that trainees are too destructive in their criticisms and do not have enough positive ideas—many perceive their consultants in this light with regard to research. In total contrast is the Professor whose encouragement and enthusiasm leads him to say to the senior registrar: 'about that project you mentioned yesterday—I've had an idea—I think you could do it this way...'.

Anyone interested in this problem could start by studying trainees at the Maudsley Hospital where there are ample opportunities for research but the three-year survival rate of M.Phil. projects is embarrassingly low. This demonstrates that it is not simply lack of opportunity which prevents successful research being completed by senior registrars; it is in fact relatively few consultants who successfully stimulate their senior registrars to do so. Completion is an added difficulty to that of starting; with rotating posts, rapid promotion and clinical commitments the time set aside for research must be sacrosant until the research is completed and written up.

Research should not just be discussed as an 'exercise' for senior registrars, which belittles the research done at this level. In a recent editorial with the ambitious title 'The Scientific Status of ECT.'[6] the two most recent studies that were discussed at length were both performed by trainees at senior level registrar level.

Whose Responsibility for Improvement?

Research is probably the best example of an activity which if left entirely to the initiative of the senior registrar may completely flounder. Apparently the Approval visitors are sometimes told by a senior registrar that he has enough time to do research when it is patently obvious that he has not—he simply does not know what research involves or how long it takes. A broader principle is involved here, namely that trainees should state their requirements and their senior colleagues should then endeavour to provide these. I do not take this view of training—trainees can only ask for what they know about—it is the trainer's responsibility to stretch their experience and learning to new fields. This is best illustrated by one of the newly appointed consultants surveyed about this training by Peter Brook in 1973[2]. The consultant wrote, 'I thought the training was good until I went to the Maudsley for six months, when my eyes were opened and I realized my formative years in psychiatry were wasted; how very much better I could have been trained'. Clearly the responsibility of trainers at all levels is to open the eyes of the trainees rather than sit for years waiting for them to wake up!

During my own career I have moved from the Maudsley,

where a complete history and diagnostic formulation form the rational basis of treatment, and discovered the practices of some other hospitals where a formulation seems unnecessary and ECT is 'tried' to see if it helps. I should stress that I refer to my deliberate attempt as APIT Chairman to find out more about psychiatric training in the more remote mental hospitals and psychiatric units rather than the hospital where I now work. My concern, therefore, is to see a *raising* of standards in psychiatry generally, which is where I see the universities have a great responsibility and the training of senior registrars is the key to this, as they are the consultants of the future.

The need to raise standards would be felt by many trainees, who are tired of being told that they are in a specialty which has difficulty recruiting enough doctors, and who also dislike associating themselves with a branch of the medical profession which is repeatedly and publicly blamed for alleged neglect and maltreatment of its patients in mental hospitals. But the inevitable changes that this involves would not be universally accepted by trainees. At present the average time that a trainee spends in the senior registrar grade is little over two years (less in some subspecialties), but the training programmes at this level have been designed to last four years. We are therefore creating a generation of half-trained psychiatrists and missing the opportunity to raise the standard, even if training programmes are better than they used to be. This is where training plans and manpower needs conflict, and in the present situation the latter are considered paramount. The universities should surely establish the importance of the former for the good of all in the long run. In his report[11] on the recent conference entitled 'Can Standards be Maintained?' Professor Pond describes the situation as 'bread for all or cake for some' but points out that no cake now will mean bread of inferior quality in the future. The criticisms of this policy recently expressed by Mezey[9] must be faced and dealt with in the long-term rather than the short-term.

If the quantity of training were increased to its rightful length the quality must also be considered. Regarding the teachers themselves Professor Walton has written[14] 'Clearly in each generation medical teachers will be likely to encumber the succeeding generation of colleagues with the erroneous constructs, the fallacious methods and the specialized scotomata that characterized the training atmosphere in which they acquired their own professional outlook'. It must be the university's role to encourage an atmosphere where this is not the case—Professor Walton enumerates aspects of research in psychiatric education to this end, but in this day of lively student criticism of their teachers the trainees can help prevent it.

Having created the right atmosphere, the university departments should ensure that all senior registrars partake of it—either by rotating posts which bring the trainees to the teaching hospital or by extending this atmosphere of critical evaluation out to the regional hospitals. The choice here is one of personal likes and dislikes and depends also on the local situation—trainees, like their seniors, have differing views, but on the whole there is a tendency for even those senior registrars at teaching hospitals to suggest that they should rotate 'out' for part of their training period.

Models of Training

Because of the differing views regarding the details of training, the starting point of any examination of the present system should be a clear definition of objectives. Peter Brook[3] sought hard for these in 1975 and came to the conclusion that 'in this country no well-defined, specific, assessable and detailed objectives have yet been formulated for postgraduate training in psychiatry'. And I am not aware that any such objectives have been formulated subsequently.

There seem to be two basic ideas—one is that well-known statement of Aubrey Lewis[8] that describes the all-round 'education' of a psychiatrist who should be able to cope with clinical problems in any area of psychiatry. As Anthony Clare[5] pointed out some years ago, with the rapid development of psychopharmacology, psychoendocrinology, psychogenetics, electroencephalography, social anthropology and medical sociology, this is becoming increasingly difficult, but the principle that the 'education' of a trainee should endow him with a set of general skills that can be applied to any particular situation would be rightly defended by many university-based psychiatrists.

The second model regards training as incomplete unless the trainee has spent a certain period of time working in each of the subspecialties as well as in general psychiatry. This has been the basis of Brook's surveys[2,4] and the formation of rotating schemes for training. Although this might seem similar to Lewis's model at first sight, I believe that it merely reflects the increasing trend away from general psychiatry towards super-specialization. This narrowing of the field of expertise comes earlier and earlier in training, and even at registrar level the trainee may have to choose child psychiatry *or* psychogeriatrics. At senior registrar level he is expected to have made this broad choice, but even in general adult psychiatry he is expected to develop *an* interest—not several interest but *one*. Obviously one cannot maintain too broad a field of interest, but with guidance a senior registrar can prevent himself becoming too narrow-minded too early on. In my own case I was most grateful when it was suggested that I should become involved in a sociological study of homelessness, as it would benefit my training if I moved away from life events and psychosomatics for some of my time. I would not have done this without the specific suggestion.

The trainee who has 'rotated' through four or six jobs during his general professional training will not have spent long enough in any one post to experience the continuity of care of patients, or been given the opportunity to integrate these 'pieces' of his training. These then become the job of the trainer at senior registrar level, and this is one reason

why the influence of the registrar training should be a prime concern of those wishing to improve higher training. The problems of registrar training, and particularly the effect that the MRCPsych exam has on this, have been discussed elsewhere.

The AUTP and the College

An urgent question in this context is the standard of the Approval Exercise carried out by the Royal College—are the standards high enough for the training schemes to produce good potential senior registrars? There is a danger with this scheme—and the College is, out of necessity, preoccupied with this problem—that raising the very low standards of the poorest hospitals is the most urgent aspect. But what about further raising the standards of the best training? This is criticized as an 'elitist' point of view, but would be my personal view of the role of the universities. Aubrey Lewis would have perhaps been more radical and suggested that, in order to maintain a satisfactory standard of approval of posts, this should not be in the hands of the same body that organizes the examination.[9]

Peter Brook[2] wrote in 1974 that the then new Joint Committee on Higher Psychiatric Training 'should formulate guidelines for programmes of training and then approve them *as speedily as possible*' (my italics). One sometimes senses that speed is more important than standards, but the Approval exercise at both levels can only bring about change and improvement if it is done slowly. Professor Shepherd told the 1969 conference on postgraduate training[13] that 'an improvement of teaching facilities in every psychiatric hospital . . . is desirable but can only be achieved by ensuring that regional psychiatric hospitals employ senior staff who have received a thorough postgraduate training and are willing and able to participate in teaching programmes. At present there are too few people who can be regarded as satisfying these criteria'. The role of the College and the Association of University Teachers of Psychiatry must surely be to ensure that the next generation of consultant staff do satisfy these criteria.

REFERENCES

[1] ASPY, D. N., 'Teaching skills'. *Journal of Medical Education*. 1978, *53*, 871.

[2] BROOK, P., 'The postgraduate education and training of consultant psychiatrists'. *Brit. J. Psych.* 1974, *124*, 109-24.

[3] BROOK, P., 'Objectives and training in psychiatry'. *Brit. J. Psych.* 1975, *126*, 550-55.

[4] BROOK, P., *Psychiatrists in Training*. British Journal of Psychiatry Special Publication No 7, 1973.

[5] CLARE, A. W., 'Training of psychiatrists'. *Lancet*. 1972, *ii* 753-6.

[6] CROW, T. J. 'The scientific status of electro-convulsive therapy'. *Psychological Medicine*. 1979, *9*, 401-8.

[7] KARDENER, S. H., FULLER, M., MENSH, I. N. and FORGY, E. W., 'The trainees' viewpoint of psychiatric residency'. *American Journal of Psychiatry*. 1970, *126*, 1132-8.

[8] LEWIS, A. J., 'The education of psychiatrists'. *Lancet*. 1947, *ii*, 79-83.

[9] MEZEY, A., 'An open letter to the President'. *Bulletin of the Royal College of Psychiatrists*. 1978, August, 147-9.

[10] NORTH, A. F. Jr., 'Evaluation of a paediatric House Officer programme by alumni'. *J. Med. Education*. 1965, *40*, 1145-53.

[11] POND, D. A., 'Health service provision for medical education in England and Wales: Can standards by maintained?' *Bulletin of the Royal College of Psychiatrists*. 1979, September, 130-1.

[12] ROYAL COLLEGE OF PSYCHIATRISTS. 'Approval visits: Guidelines on criteria and facilities for training'. *Bulletin*, 1978, September, 158-9.

[13] SHEPHERD, M. In *The Training of Psychiatrists* (Ed Russell and Walton). British Journal of Psychiatry Special Publication No 5. 1970 p 90.

[14] WALTON, H. J., 'Research in psychiatric education'. *Psychiatric Quarterly*. 1972, *44*, 532-42.

Reports and Pamphlets

'Tied Together With String' by Diana Priestley
'Home Sweet Nothing'
Both published by the National Schizophrenia Fellowship

In the rather complex world of voluntary organizations and pressure groups (often hiding under dramatic titles), the National Schizophrenia Fellowship has been marked out by its eminently practical aims and by its firm alliance with professional workers. This does not stop it, though, from being highly critical where services are poor. It has also sought to provide some protection and comfort for the families of schizophrenics from the odium heaped on them by environmental doctrines of aetiology, such as those of Laing and Lidz—wholly unproved though those theories remain. The NSF's modest programme of publications has been of such high quality that they are already widely quoted, and the latest two are well up to standard.

One of the Fellowship's initiatives was to provide a professional advisor/coordinator for relatives of schizophrenics in one Health Area (Surrey) over a two-year period. Acting directly for families, she was to identify gaps in the services provided and try to improve communications between all their staffs and the users. Mrs Priestley has written an impressive account of her experience, not least because she had to start by defining the functions of a new kind of professional worker. Focussing on needs that are not being met, she describes the local organization of the NHS