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The College

Joint statement on general practitioner vocational training in psychiatry

The Royal College of General Practitioners and The Royal College of Psychiatrists

(1) A Joint Working Party of the Royal College of General Practitioners and the Royal College of Psychiatrists prepared a report on training general practitioners in psychiatry in 1974. This was circulated to all regional advisers and course organisers and was published in 1978. Since that time, there have been advances in the treatment of patients with psychiatric disease and considerable change in the organisation of health care services which have resulted in an increasing proportion of psychiatrically ill people being cared for in the community rather than in the hospital setting. With these changes in mind, both Colleges felt that it would be appropriate to convene another joint working party to review the arrangements for the psychiatric component of vocational training for general practice. This report revises the objectives for training that were agreed in 1974 and makes recommendations for the organisation that will achieve them.

(2) The membership of the working group was Dr Fiona Caldicot, Dr Alasdair McKechnie and Professor Roy McClelland from the Royal College of Psychiatrists and Dr Andrew Elder, Dr Michael Fisher and Dr William Styles from the Royal College of General Practitioners.

(3) Hospital posts used for general practitioner vocational training are normally at the SHO grade. At this stage of training there is considerable overlap in content for doctors preparing for careers in general practice with those who are preparing to be specialists in psychiatry. There is scope for sharing the training of future general practitioners with that of future psychiatrists. This could be developed within the setting of general practice as well as in association with hospital posts and joint meetings and courses.

The content of training in general practice

(4) Caring for people with emotional disturbance and psychiatric illness occupies a considerable amount of a general practitioner's time. In any one year, only about 5% of people with mental illness obtain specialist care. The general practitioner's responsibilities include the total management of people with a broad range of mental illness, the emergency care of florid psychiatric states and the continuing care of those with recognised long-term psychiatric states and the continuing care of those with recognised long-term psychiatric conditions, such as schizophrenia, manic depressive illness and dementia. The transfer of psychotic and highly dependent patients from in-patient hospital care to a range of community settings, including nursing homes, will mean a considerable increase in the general practitioner's future involvement in caring for them. The effective fulfilment of the general practitioner's responsibilities in this field will require a team approach to care with the integration of services provided by community psychiatric nurses, clinical psychologists and social workers, and the sharing of the care of some patients with consultant psychiatrists.

It is crucial that posts in general and old age psychiatry offer suitable experience in the management of acute, recurrent and chronic psychiatric illness. Sessions in child and adolescent and learning disability psychiatry, and paediatrics, can provide experience in important aspects of working with patients and their families.

The interaction between physical and mental health should also be covered.

Training in psychiatry can provide a valuable component for the general practitioner trainee in acquiring interviewing skills.

(5) As well as keeping abreast of changes in the health care system, the general practitioner must maintain knowledge of developments in psychiatric care, and the principles of rational prescribing of psychotropic drugs, including in particular the advantages and disadvantages of new psychotropic drugs and the indications for their use, as well as the indications for non-pharmacological forms of management.

(6) Training in psychiatry, with its emphasis on multiprofessional work and its encouragement to

TABLE I
Percentage of certificates to be issued to doctors who submitted hospital experience in psychiatry: 1986–1991

	1986 (n=2196)	1987 (n=2237)	1988 (n=2198)	1989 (n=2186)	1990 (n=2112)	1991 (n=2128)
Psychiatry	37.8	39.8	39.6	41.9	40.7	43.2

(Information from the Joint Committee on Postgraduate Training for General Practice)

TABLE II
Number of SHO posts in psychiatry in the United Kingdom at 30 September each year (aggregated information from the Department of Health, Scottish Health Service and the Northern Ireland Council for Postgraduate Medical Education)

	1985	1986	1987	1988	1989	1990	% Change 1985–1990
Psychiatry	1040	976	962	1016	1111	1122	+7.9

understand the psychological aspects of human relationships may be particularly relevant for the future general practitioner. Such training can also help doctors to recognise the particular need for educational and emotional support of doctors and those working in other professions who come into contact with mentally disturbed patients. Good staff morale is crucial in ensuring that a high quality of service is provided to such patients.

(7) In recent years, both public and professional opinion has tended to swing away from the use of psychotropic preparations in the management of emotional disorders and lesser degrees of mental illness. The general practitioner must develop the skills appropriate for psychiatric care within the setting of general practice. These would include skills in counselling and in the management of stress as well as an understanding of family therapy, psychodynamic psychotherapy, cognitive and behavioural therapy and crisis intervention. He/she must be able to recognise when other forms of treatment are more appropriate and should have knowledge of those agencies and professions who can provide care, support and treatment.

The setting of vocational training in psychiatry

(8) Table I shows that only about 40% of doctors completing training for general practice offer experience as a senior house officer (SHO) in psychiatry when applying to the Joint Committee on Postgraduate Training for General Practice for a certificate that will enable them to become principals within the National Health Service. This figure has increased slowly from 37% in 1986 to almost 43% in 1991. There is considerable scope to improve upon these figures and the joint working party recommends that both Colleges should direct their attention towards increasing this proportion, since the achievements of many of the objectives presented in Appendix 1 can be readily met through experience as an SHO in psychiatry.

(9) As well as taking place in the hospital, training in psychiatry for general practice also occurs in two other settings. These are the 12 month attachment in general practice as a trainee and during the half/day release courses that are organised by vocational training course/scheme organisers. Indeed, for 60% of those completing vocational training, experience in psychiatry occurs only in these latter two settings. Nevertheless, the joint working party would expect all doctors completing vocational training for general practice, whether or not they had obtained experience as an SHO in psychiatry, to have achieved the objectives set out in the appendix to this report. It is particularly important therefore that at a local level general practitioner vocational training course/scheme organisers and local consultant psychiatrists should agree how these objectives will be achieved for both groups of trainees – that is, those with and those without experience as an SHO in psychiatry.

(10) Table II presents the number of SHO posts in psychiatry in the United Kingdom at 30 September between 1985 and 1990 and shows that during this period there was an increase in the number of SHO posts in psychiatry of almost 8%. In 1990 there were 1,122 SHO posts in psychiatry.

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Almost 2,200 certificates are issued each year by the Joint Committee on Postgraduate Training for General Practice and it should be possible for a higher proportion of future general practitioners to obtain experience as an SHO in psychiatry, certainly up to a figure nearer 60% than the 40% currently achieved. It should be possible to reach this by the more effective utilisation of the posts currently available and by ensuring that an SHO preparing for general practice spends no longer than six months in this specialty. Both Colleges believe that the ideal is for six months' experience to be obtained in psychiatry as an SHO. A post combining three months in general psychiatry and three months in old age psychiatry is particularly beneficial. For those wishing to develop a special interest in psychiatry in general practice, additional training time in a hospital post would be valuable.

In the immediate term, the creation of four month posts, so that in each year three, rather than two, trainees could work in a given post, could be considered. However, in the view of some psychiatrists, such short placements will provide inadequate training in the management of much psychiatric illness, due to its recurrent and long-standing nature and would not be in the interests of patients and other hospital staff.

The process of training

(11) Although it is important to agree the content of training in psychiatry and to ensure that there are adequate opportunities for intending general practitioners to obtain this, it is equally important to agree the arrangements that will encourage learning in this specialty. Recently published work about training in a range of junior hospital posts has highlighted consistently that in general their educational value is not being fully exploited. These reports reiterate the common criticisms that insufficient time is made available for formal teaching and that the trainees themselves are unclear about what it is that they are expected to learn. Some have been confused about the services that they are expected to provide to patients and some have expressed alarm about the lack of induction arrangements when beginning new posts, and in particular when being called upon to cope with emergency and often life threatening conditions. A major problem has been that in many districts the pressure of service work results in an imbalance in the learning experience available to trainees and erodes the proportion of protected time for postgraduate medical education considerably. This balance must be redressed if the quality of training is to improve and, through this, standards of care for patients are to be enhanced.

(12) The working party believes that there should be local discussions between general practitioner course/scheme organisers, trainers and consultant psychiatrists about how the content of vocational training outlined in the appendix to this report is to be achieved, and in which settings – training practices, half/day release courses or through SHO appointments. Local programmes for the psychiatric component of vocational training for general practice should be developed by general practitioners and psychiatrists together and the methods for achieving their objectives should be clearly stated. Opportunities for joint training in general practice and psychiatry should be encouraged. Every trainee should work under close supervision until consultant and general practitioner trainers are satisfied that he/she has the knowledge and ability to work more independently.

(13) Although the content and methods of training need to take account of a doctor's future career intention, nevertheless there is some overlap between the objectives for a future career in general practice and those for a future career as a consultant psychiatrist. There are core experiences that can be shared by all doctors in the SHO grade and there is considerable merit in the local development of shared learning opportunities for these two groups. The arrangements for these should be addressed through local discussions between general practitioner and psychiatrists' trainers.

It is also recommended that much greater attention should be paid to identifying the core experiences which can be shared by doctors entering a range of specialties, e.g. neurology, obstetrics, paediatrics, as well as psychiatry and general practice.

(14) For general practitioner trainees there may need to be a re-orientation of some hospital posts so that there is a greater community element to them. When working in psychiatry, general practitioner trainees welcome opportunities to work in out-patient departments, to look after patients in day hospitals, and for seeing patients in the settings of their own homes by attending domiciliary visits with consultants and other members of the multidisciplinary team. A multidisciplinary approach to caring for mental illness in general practice is particularly important, so that joint training sessions with nursing and social work colleagues are of particular value for trainee general practitioners.

(15) Job descriptions of SHO posts in psychiatry should identify clearly their educational content and the methods of achieving it, as well as stating the service obligations. Trainees will find it helpful if the knowledge and competencies that they are expected to acquire from each post are clearly defined and agreed locally. A log book may be helpful in this. In

psychiatry, there is a particular need for professional supervision that includes time for a young doctor to gain support through reflecting about his or her own reactions to working with mentally disturbed people. Psychotherapists working in a medical setting, whatever their original professional background, have a particular contribution to make to this aspect of training and this should be encouraged.

(16) Local discussions between general practitioner courses/scheme organisers, trainers and consultant psychiatrists will clarify many of these issues. This report is intended to provide an agenda for such local discussion and in addition should form the basis for the joint College review visits to psychiatric posts that are undertaken as part of the general professional training approval process for hospital posts.

(17) The General Medical Council has identified the need for explicit protected time for learning and for its supervision to be undertaken by a clearly identified and named person for each appointment. Both Colleges strongly endorse these views as well as the more general attributes of the independent practitioner that the General Medical Council has promulgated and which is presented as the second appendix to this report.

(18) Both Colleges require that there should be regular attendance of trainees at the general practitioner half/day release courses that are organised for them at all stages in the training programme, including the hospital attachments. These events are important elements for integrating the overall content of vocational training for general practice. They provide trainees with continuing contact with their peers and enable them to relate their experiences in specialist hospital work to their future responsibilities within the wider community. The development of local initiatives for protected time for training within psychiatry is to be encouraged.

(19) The service pressures of SHO posts sometimes can prevent the regular attendance of some hospital based trainees at these courses. Course organisers and consultants need to address these problems locally so that solutions can be identified to ensure regular half-day attendance throughout the three year programme. Attendance should not result in additional pressure on a trainee's SHO colleagues and it may be that mechanisms will have to be found to provide additional cover, possibly by employing doctors at the staff grade or as hospital practitioners/clinical assistants. By working together, consultant and general practitioner teachers should be able to agree proposals, so that jointly they can approach hospital managers to ensure that the necessary arrangements can be made.

(20) The Colleges would wish to see opportunities developed for integrating the SHO training of future general practitioners with that of future psychiatrists, particularly in those elements of practice that are shared by both disciplines. There will be a core curriculum essential for both groups of trainees that will contain mental state examination, the formulation of cases and various types of treatment that will include the psychotherapeutic as well as the pharmacological. Social psychiatry will be another area in common. At a local level it should be possible to construct a creative programme with core elements for both sets of trainees. An important consequence of such shared learning during the junior doctors' years is likely to be more the effective sharing of patient care later in doctors' careers. Ways of increasing the contribution of general practitioner teachers to the training of future psychiatrists should also be explored through local discussion.

(21) There is scope to improve upon the quality of training and education by observing certain basic principles. This report is intended to help those locally to agree the content of programmes and to devise appropriate methods for achieving them. The quality of training can be improved if the principles of adult learning are applied and, in particular, if learners themselves are given opportunities to identify what it is that they still need to learn and how they might achieve this. Participative activities such as small group discussions are particularly relevant to education and training in psychiatry and can contribute to a clearer understanding of interpersonal relationships, between doctor and patients and between doctor and colleagues. Suitably trained psychotherapists can make an important contribution to the leadership function that such small group discussions require. Case discussion based on methods developed by Michael Balint have much to contribute to this. Project work also has much to commend it as a participative form of learning and a way of encouraging a critical and questioning approach to practice. The incorporation of medical audit into training in psychiatry is recommended as an important way of working towards this.

(22) In recent papers, trainees have expressed their dissatisfaction about the limited feedback to them of their performance. They want to know the views of their teachers about how well they are doing and they want to be able to determine their progress in achieving previously defined objectives. The value of assessment as part of continuing education is widely acknowledged. Regular and frequent assessment with the feedback of results to learners should be part of the educational process for all trainees working in psychiatry. It becomes easier once the objectives for each post have been clearly defined and discussed

with each trainee at the beginning of each attachment. The system developed by the Royal College of Psychiatrists for the regular assessment of the progress of trainees in psychiatry should be extended to all junior doctors working in psychiatric posts, with reports of progress being made available regularly to local general practitioner course organisers.

Local discussions

(23) One of the aims in publishing this report is to encourage local dialogue between general practitioner course organisers and trainers with consultant psychiatrists. The working party recommend that these groups meet together at least once a year to agree local policies for the psychiatric component of vocational training for general practice and to monitor their implementation through an agreed programme of learning. Such meetings could address the following agenda:

- protected teaching time and how it will be found
- the content of the programme and its relevance to the needs of future of general practitioners
- study leave arrangements
- release for half/full day courses
- induction programme
- identification of educational supervisors
- career counselling arrangements
- methods for teaching and the place of learning
- multi-professional aspects of training involving nurses and social workers
- ways in which general practitioner teachers can contribute to the learning of future psychiatrists
- the range of assessment methods, their timing and the use made of results
- the balance of training between in-patient, day-patient and out-patient experience and general practice experience
- provisions for medical audit and the use of its outcome
- access to books and journals relevant to general practice psychiatry.

(24) A local general practitioner, who may be one of the course/scheme organisers could have specific responsibility for maintaining links with local psychiatrists throughout the year, and for ensuring that the review meetings described in the previous paragraph take place.

The approval of hospital posts

(25) Both Colleges work together in the approval of psychiatric hospital posts for general professional training purposes. The regulations for vocational training for general practice give responsibility to the regional postgraduate organisations for selecting from the posts that have such Royal College approval those that are suitable for vocational training for general practice. It is by working in these selected posts that doctors acquire prescribed experience and ultimately the certificate from the Joint Committee on Postgraduate Training for General Practice that will enable them to become principals within the National Health Service.

(26) The recommendations contained in this report for the content and methods for the psychiatric component of vocational training for general practice should represent the criteria by which hospital psychiatric posts should be judged for general professional training purposes, and should provide information to regional organisations that will guide them in the selection of posts for general practitioner training.

Summary of recommendations

The Royal College of General Practitioners and The Royal College of Psychiatrists recommend that:

(a) A greater proportion of doctors completing training for general practice should acquire experience as an SHO in psychiatry (paragraphs 8, 9, 10). There need to be greater opportunities for learning within the primary care setting.

(b) Discussion should be established at local level between general practitioner vocational training course/scheme organisers, clinical tutor and local consultant psychiatrists to agree how the objectives for training in psychiatry specified in this report can be achieved by all doctors training for general practice (paragraph 9). The outcome of these discussions should be communicated to the regional adviser in general practice and to the regional adviser in psychiatry.

(c) The local arrangements for the psychiatric component of vocational training for general practice should ensure that trainees are clear about what it is that they are expected to learn, and that there is sufficient time available for formal teaching and induction programmes at the beginning of posts to ensure that each trainee can cope with emergency and life threatening conditions (paragraph 11).

(d) Every trainee should work under close supervision until his/her consultant or general practitioner trainer is satisfied that he/she has acquired the knowledge and ability to work more independently (paragraph 12).

(e) The content and methods for general practitioner training in psychiatry should take account of future career intention by ensuring that there is an adequate community element and a multi-professional approach to learning (paragraph 14).

(f) Job descriptions of SHO posts in psychiatry should identify clearly their educational content and the methods for achieving it as well as stating the service obligations (paragraph 15).

(g) Both Colleges support the recommendation of the General Medical Council (9) for the need for explicit protected time for learning to be available and for the supervision of training to be undertaken by a clearly identified and named person for each appointment (paragraph 16). These requirements will be viewed as mandatory in approving posts.

(h) Both Colleges endorse the general attributes of the independent practitioner, as promulgated by the General Medical Council (paragraph 7). Opportunities should be created for shared learning by general practitioner trainees with those pursuing a career in psychiatry (paragraph 16).

(i) Local arrangements should ensure the regular attendance of trainees at general practitioner half/full day release courses and other approved academic programmes during SHO posts in psychiatry (paragraphs 18 and 19).

(j) The quality of training and education will be enhanced if the principles for adult learning are applied, and in particular if learners are given the opportunity to identify what it is that they are expected to learn and how this might be achieved.* Participative activities such as small group discussions, project work and medical audit are particularly recommended (paragraph 21).
*Documentation, such as a log book, would enable this to be ensured.

(k) Regular and frequent assessment of the performance of trainees with the feedback of the results should be part of the educational process for all trainees working in psychiatry (paragraph 22).

(l) General practitioner course organisers, trainers and the consultant psychiatrists who contribute to vocational training for general practice should meet together regularly, at least once a year, to agree local policies for training in psychiatry and to monitor their implementation through an agreed programme of learning. A possible agenda for such meetings is presented in paragraph 23. A local general practitioner involved in vocational training should be responsible for ensuring that such review meetings take place (paragraph 24).

(m) The recommendations for the psychiatric component of vocational training for general practice contained in this report should represent the criteria by which training posts in psychiatry are judged for general professional training purposes, and should guide regional organisations in the selection of posts for general practitioner training (paragraph 26).

Such training may occur in a range of settings and should include time spent in the community, and the opportunity to visit services of relevance, such as those in child psychiatry, learning disability and old age psychiatry.

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Copies of the References, Suggested Reading List and Appendices 1 and 2 are available on request to the Publications Department at the College.