that he is satisfied with the staff with whom he actually works and be prepared ultimately to withdraw his service if his needs are not met; (c) he should ensure that there is a clear distinction made between cases that are referred to him and that he is involved with and those where he is not involved; the latter are then clearly not part of his responsibility; (d) he needs also to make it clear that in cases referred to him, and in others where he is consulted, he needs to have some continuing oversight until the children are discharged from the clinic; (e) if he receives no guarantee about confidentiality of notes in the clinic, in general, he should consider whether he should have a separate filing cabinet for his own notes; (f) it would be helpful if job descriptions for new consultant appointments made clear what was the extent of consultants' responsibilities for children referred to the team and not to him by name.

7. An allied problem is that of leadership. This has been diffused in the same way as medical responsibility, with the strengthening of the professional identity of other disciplines. The voices of the multidisciplinary team echo weakly in the corridors of power, especially where there is no clear leader to negotiate for resources or where the Health Service is seen as the 'poor relation' compared with other services. There needs to be a clearly designated team leader, and if this is not the consultant psychiatrist the clinical responsibilities of his work which cannot be directed by non-medical team leaders must be clearly separated from other leadership roles.

FOOTNOTES

1. Presented at the Section's Annual Residential Meeting, Cambridge, September 1979.
2. 'The Role, Responsibilities and Work of the Child and Adolescent Psychiatrist'. *Bulletin*, July 1978, p. 127.
3. The General Medical Council in their guidance on professional conduct and discipline (May 1977) state: 'It is the doctor's duty strictly to observe the role of professional secrecy by refraining from disclosing voluntarily to any third party information which he has learned directly or indirectly in his professional relationship with the patient'. The Council would also regard it as a breach of medical responsibility if:
   (a) a doctor failed to 'provide or arrange treatment for a patient when necessary' and
   (b) the doctor delegates treatment or other procedures requiring the knowledge and skill of a medical practitioner to someone without satisfying himself that 'the person to whom they are delegated is competent to carry them out'.

   The Council go on to say, 'It is important that the doctor should retain ultimate responsibility for the management of his patients because only the doctor has received the necessary training to undertake this responsibility'.

*General Practice Trainees in Psychiatry**

The joint Liaison Committee of the Royal College of Psychiatrists and the Royal College of General Practitioners has recently agreed to guidelines dealing with the experience that would be desirable for a general practitioner trainee occupying a post in psychiatry. The draft Guidelines have now been accepted by the Councils of both Colleges and are commended to all those concerned with the psychiatric education of vocational trainees in general practice.

Experience desirable for the General Practice Trainee occupying an SHO Post in Psychiatry: Guidelines

Introduction

Suitable hospital experience is recognized to be an important part of postgraduate preparation for general practice. The concentration of clinical material and the ready supervision by appropriately experienced colleagues can rapidly enhance clinical skills and help to bring about professional maturing with a general gain in competence and confidence. First-hand knowledge of hospital procedures and of what hospitals can offer is of importance to general practitioners. At the same time a perspective on the relationship between general practice and specialist services is achieved from the hospital standpoint.

The following notes are intended as pointers to areas of knowledge and clinical practice in psychiatry with which general practitioners should be familiar, and to enable psychiatric consultants to help their general practitioner trainees occupying SHO posts to acquire a sound basis for their future practice of family medicine. The relationships established in this way can be of great benefit to both branches of the service, as well as to patients.

Local conditions will undoubtedly influence the way these proposals are implemented, and variety of approach is not only to be expected but welcomed. Close co-operation will be required between a number of individuals, particularly the regional postgraduate adviser in general practice, the Royal College of Psychiatrists' regional adviser, the local psychiatric tutor and the vocational training scheme organizer.

The immediate objectives of the general practitioner trainee and the trainee psychiatrist may differ in a number of important respects. For instance the requirements of the respective postgraduate examinations are different and the emphasis on range and content of training also differs. On

*See also *President's Press* on page 86 of this issue.

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the other hand there are areas of knowledge and practice which are common and which during the training period could be shared to the advantage of both; it is in this connection that the consultant psychiatrist can be of particular help.

Apart from frank psychiatric illness, a significant psychological component is present in a large proportion of patients seeking advice from their family doctors so it is an advantage for the trainee to have an opportunity of gaining wide working experience in the field of psychological medicine and mental health. In view of the ground to be covered, a tenure shorter than six months might be regarded as less than optimal, but there is need for a study in which posts of different lengths are evaluated.

It must not be forgotten that certain essential experiences (such as psychiatric aspects of chronic physical illness) cannot always be covered in SHO psychiatry posts but may be better acquired in other learning situations, such as the teaching practice.

Areas of Experience

During a six-month tenure it should be possible to obtain worthwhile experience in the following areas:

1. General psychiatric practice, including interview techniques, taking case histories, and making formal diagnoses.
2. Methods of psychiatric treatment, especially the proper use of psychotropic medication and of the more simple psychotherapeutic procedures.
3. Application of the Mental Health Acts, with particular reference to the responsibilities of general practitioners.
4. Management of acute psychiatric emergencies.
5. Recognition and management of potential psychiatric emergencies.
6. Liaison with professional workers in the community, especially general practitioners, social workers, and community psychiatric nurses.

In addition the following areas should be covered, if not by actual clinical experience then by seminars, etc.

7. The long-term care of chronically disabled psychiatric patients.
8. Psychiatric aspects of the aged.
9. Diagnosis and treatment of psychosexual conditions.
10. Counselling, for example in family crises and marital problems.
11. Miscellaneous areas of special experience, such as child and family psychiatry, adolescent psychiatry, mental handicap, forensic psychiatry, and dependence on alcohol, tobacco and other drugs.

1. *General Psychiatric Practice*

Introduction to general psychiatric practice, especially case-taking, diagnostic procedures, and initial therapy, can best be achieved by the trainee being allocated to a psychiatric firm for a short induction period of a week or so. Some psychiatric hospitals and centres provide a short guide on medical administration, admission procedures, case-taking, the Mental Health Acts, postgraduate teaching programmes, etc., and this is much appreciated by newcomers.

On completion of the induction phase the work of the trainee as a member of the team, firm or sector should include a range of duties involving care of short-term as well as of long-term patients in both out-patient and in-patient settings, and including the medical duty rota. These duties, which involve case-taking, undertaking diagnostic procedures, carrying out treatments, interviewing relatives and dealing with admissions, should be under registrar, senior registrar or consultant guidance and instruction, but with increasing clinical responsibility. The trainee could accompany the consultant on domiciliary visits from time to time.

Some trainees may find disturbed patients particularly stressful and should be able to look to an experienced colleague for the necessary support.

2. *Methods of Psychiatric Treatment*

The range of duties in the apprenticeship suggested above will introduce the trainee to a relatively wide range of treatment procedures, the rationale of which will be explained by the supervising medical staff. Knowledge and experience is particularly necessary in connection with side effects and interactions of various psychotropic medicines. In addition, knowledge of other methods is desirable, as well as some practical experience in simple psychotherapeutic measures and of alternatives to in-patient care such as the day hospital.

3. *The Mental Health Acts*

From time to time the general practitioner will be involved with the operation of the Mental Health Act in force in his part of the United Kingdom. The SHO trainee participating in a full range of duties should gain practical experience in the application of various sections of the Act and in liaising with local social service departments.

4. *Acute Psychiatric Emergencies*

The range of duties should provide experience in recognizing and managing various acute psychiatric emergencies involving states of severe agitation and distress, impulsive acts, alcoholism and suicidal attempts.

5. *Potential Psychiatric Emergencies*

The trainee general practitioner can obtain practical instruction in the recognition of such cases in the course of ward rounds and at postgraduate seminars and journal clubs. These cases include serious depressive conditions, atypical depressions and psychoses, and some types of drug abuse.

6. *Liaison with Community Services*

The trainee should be encouraged to liaise with community services and to take part in multidisciplinary

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case conferences, especially those attended by professional workers in the community, such as general practitioners, social workers and community psychiatric nurses.

7. *Chronically Disabled Psychiatric Patients*

In view of the increasing number of chronically disabled patients now being cared for in the community by general practitioners with or without community psychiatric services, the trainee general practitioner must be able to recognize the needs of such cases in order to arrange appropriate care, treatment and rehabilitation (for instance by attendance at a day centre), or to arrange specialist advice and help. The trainee should have experience of patients receiving lithium therapy or depot injections of psychotropic drugs, and of methods of behaviour therapy for phobic conditions, alcohol dependence, etc.

8. *Psychiatric Aspects of Old Age*

Because of the widespread problems involved in the care and management and treatment of aged mentally disabled people in the community and in hospital, it is important that this area of experience should be included among the duties of the trainee, especially the recognition of depression, senile dementia and the physical and remediable causes of confusion. Experience should include a community setting and contact with appropriate community social agencies.

9. *Psychosexual Conditions*

There are relatively few centres where specialist experience in the diagnosis and treatment of psychosexual conditions can be obtained, but in view of the frequency of such problems in general practice the trainee might obtain insight from the hospital or unit if suitable experience is available. It is also necessary for the trainee to be aware of the effects which psychotropic medicines may have on sexual function.

10. *Family Crises, Marital Problems, and Counselling*

The general practitioner can be confronted with emotional problems associated with serious physical or mental disablement, the effect of acutely distressing medical information, of bereavement, marital conflict and many other situations in which a counselling approach is appropriate. The trainee cannot, however, hope to obtain sufficient counselling expertise within a single psychiatric SHO appointment of only six months.

11. *Special Areas of Experience*

In his relatively short tenure the trainee general practitioner would not normally participate in the specialty secondment or rotations necessary for the trainee psychiatrist, but any experience of child and family psychiatry, adolescent psychiatry, mental handicap, forensic psychiatry, and the treatment of dependence, though hardly representing more than an exposure, would nevertheless be helpful.

Postgraduate Educational Activities

The holder of an SHO post, whatever the specialty, is in training and must expect to supplement his in-post experience by a variety of learning activities, whether planned beforehand or *ad hoc,* both within the hospital where he works and outside. The postgraduate psychiatric tutor or the GP course organizer can advise on the availability of such activities and may be in a position to organize an individual programme, including special attachments.

Full use should be made of libraries, both in the department and in the postgraduate centre; and every effort should be made to attend audit and patient management reviews in the department, interdisciplinary meetings, and clinicopathological conferences of wider interest.

The concept of general professional training implies that in-post teaching should primarily be about the specialty itself, whatever the incumbent's eventual career destination. However, those trainees in hospital who are preparing themselves for general practice possess in the local day or half-day release course an opportunity to maintain contact with their peers and to take part in a programme of group work during which their specialty teaching can be related to the wider perspectives of general practice.

Report on Non-Consultant Medical Staffing Needs: Adult Mental Illness

This Report has been drafted by a Working Party of the College's Manpower Committee, which was set up to consider the medical staffing structure other than consultant, and also the contribution of the allied professions. The Working Party's recommendations on the first part of its remit are being circulated for discussion.*

*Members of the Working Party were Professor Steven Hirsch, Drs Fiona Caldicott, John Cobb, Francis Creed and Ashley Robin.

Background

The Manpower Committee has so far confined its discussion to establishing levels for consultant staff in all psychiatric specialties and special interests. These have been related to the population served and the recommendations have been passed to the Central Manpower Committee and to the Department of Health and Social Security.

Senior registrar and registrar posts are controlled centrally by the Central Manpower Committee (CMC) and dis-

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