the columns

correspondence

Helping the recruitment cause in psychiatry: a postmodernisation promise

Boyle *et al*[1] have highlighted some of the important positive aspects of foundation year placements in influencing career choice into psychiatry. The jubilant article carries an optimistic account from trainers and trainees who share the champagne of successful mentoring. Unfortunately, the darker side of wider experience while seeking foundation placements in psychiatry has been overlooked.

The number of places available for FY1 and FY2 placements in psychiatry are very limited, and as of now not representational of subsequent requirements the specialty has during core training. There is an urgent need for such 'potential demand' *v.* supply statistics to be made clear and compared across various specialties. The perennial recruitment issue could be seen in correct perspective when level playing fields are ensured following the implementation of Modernising Medical Careers.

Despite being a trainee with significant interest in exploring psychiatry as a career choice, the placements in my current FY2 rotation were ready-made with no element of choice. On the wake of Boyle *et al*'s account, it is important to solicit and analyse national data on foundation placements in psychiatry and rate of conversion into core psychiatric training. Creating such foundation maps of potential psychiatry placements across deaneries may help interested trainees to plan their careers. One could argue that psychiatry must be given more foundation slots than some relatively oversubscribed specialties.

If one is allowed to make a deduction from personal experience, most specialties look at foundation doctors as inconsequential cogs in the churning wheel of hospital machinery. Very few minutes in the 120 days of a foundation placement are spent in motivating the trainee to consider a specific specialty career. In addition, the educational meetings and professional activities in most hospital units tend to concentrate either on core trainees or making a 'safe doctor' out of foundation trainees. There is an immense hidden potential for psychiatry to convert a substantial number of hesitant doctors into promising and passionate specialists for the future, if some collective and timely effort is taken to recognise the prospect here.

Bearing in mind that at least a quarter of all psychiatrists explore other specialties before choosing psychiatry as their career,[2] making foundation year psychiatry more accessible will serve our recruitment cause a great deal.

1 Boyle AM, Chaloner DA, Millward T, Rao V, Messer C. Recruitment from foundation year 2 posts into specialty training: a potential success story? *Psychiatr Bull* 2009; **33**: 306–8.

2 Dein K, Livingston G, Bench C. 'Why did I become a psychiatrist?': survey of consultant psychiatrists. *Psychiatr Bull* 2007; **31**: 227–30.

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Home visits for older people: a practical model outside Yorkshire

Professors Benbow & Jolley invite us to 'set the record straight' in agreeing with them that 'in many good services for older people home visits are the reality'.[1] We are pleased to concur with them and refer them to the title of our paper.[2] However, they appear to be confusing 'community clinics' with community-oriented mental health services.

In her original paper,[3] Professor Benbow described replacing a psychiatric out-patient clinic with what she designated a 'community clinic', whereby the catchment area was divided into four geographical areas, each being visited by the psychiatrist once every 4 weeks. To our knowledge, this model has not been adopted elsewhere, or if it has, no one has written about it in peer-reviewed journals. Elderly mental health services in Sheffield are not resourced to provide such a service. If services were reconfigured in this way, psychiatrists' time would be deflected from community mental health team (CMHT) work or other community-oriented work such as the dementia rapid response team and the (functional illness) discharge and rehabilitation team.

Our paper does not in any way suggest replacing community work with out-patients; what we are advocating is efficiently run out-patient clinics in the context of well-coordinated community-oriented services. Older patients who are independently mobile are capable of attending an out-patient department, as they do for appointments in general hospitals. For psychiatric patients who are immobile, house-bound, refusing to attend, or in residential/nursing homes, in Sheffield they are seen in their own home either by a psychiatrist or another CMHT member.

The purpose of our simple questionnaire study was to assess user and carer acceptability of attending psychiatric out-patients. The majority of older users and carers were highly satisfied with all aspects of their attendance, irrespective of the seniority of the psychiatrist seen, and we believe our findings are potentially transferable outside Sheffield.

Professors Benbow and Jolley have made a useful contribution to the literature in logging the activity of old age psychiatrists in different settings. It is equally valid to ask old users and carers of services what they think of this activity.

1 Benbow SM, Jolley D. Doctors in the house. Home visits for older people: a practical model outside Yorkshire. *Psychiatr Bull* 2009; **33**: 315.

2 Negi R, Seymour J, Flemons C, Impey M, Thomas N, Witrylak R. Psychiatric out-patient clinics for older adults: highly regarded by users and carers, but irreplaceable? *Psychiatr Bull* 2009; **33**: 127–9.

3 Benbow SM. The community clinic – its advantages and disadvantages. *Int J Geriatr Psychiatry* 1990; **5**: 119–21.

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