Medical Education

Psychiatric training: the consultants' view

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Summary

All consultants in general psychiatry appointed between 1 October 1972 and 30 September 1975 were sent a questionnaire asking about their training experience in various aspects of psychiatric practice. The results showed that the standards of training in 13 areas of psychiatry were generally poor, although psychiatrists who had trained at the Maudsley Hospital had generally had better training than those who had worked in psychiatric hospitals. Perhaps the most alarming feature was the general lack of improvement over the past nine years.

It will be several years before the effects of the visits of approval made by the Royal College of Psychiatrists can be seen and assessed. Meanwhile the demands for a fairer share of experience for all trainees can perhaps be met by introducing rotational programmes that include both teaching and psychiatric hospitals.

Introduction

How well are psychiatrists trained in their specialty? As long ago as 1969 the Royal Medico-Psychological Association drew attention to many deficiencies in training reported by recently appointed consultants.¹ Later surveys²⁻⁴ showed that although some improvements were being made, the average level was still unsatisfactory. Trainees in psychiatry expressed their unhappiness about the introduction of the new membership examination of the Royal College of Psychiatrists⁵ unaccompanied by the corresponding improvement in training that the new examination would demand. At the same time the *Lancet* drew attention to the discrepancies in educational facilities between the best and the worst institutions.⁶

A brief account is given here of the most recent survey of the training experience of newly appointed consultants. A full account will be published elsewhere.

Method

A postal questionnaire was circulated to all 209 consultants (NHS and honorary) in general psychiatry in the UK who had been appointed between 1 October 1972 and 30 September 1975. The consultants were asked to rate their training in 13 areas of clinical experience on a four-point scale: 1=Adequate in quantity; adequate consultant supervision. 2=Adequate in quantity; inadequate consultant supervision. 3=Inadequate experience. 4=No experience.

A similar four-part scale was used to assess training in a further 11 areas of more specialised experience. The respondents were told to "use the criterion of being prepared for a consultant post when considering adequacy." The second half of the questionnaire inquired about parental background, psychiatric experience, personal details (including sex and the country where qualified), qualifications, career choice, and alternative careers that would have been taken up if the respondent had failed to get a consultant post in general psychiatry.

The results reported here are an analysis of the 13 areas of training about which fewer than half the consultants expressed complete satisfaction. The results were compared with those from three earlier surveys to gauge whether training standards had improved over the nine years.

Results

One hundred and fifty-one NHS and 25 honorary consultants replied, giving a response rate of 84%. The respondents were divided into four groups on the basis of the type of hospital where they had spent the most time as registrars. Ninety-five doctors had spent the most time in psychiatric hospitals and units (group 1), 52 had trained in teaching hospitals, and 18 had trained in the Bethlem Royal and Maudsley hospitals. Eleven consultants had been registrars in overseas hospitals or with the armed Forces, and they have been excluded from the table because their training was not typical. One consultant who trained in a teaching hospital did not complete the section on adequacy of training.

Thirty-five consultants (20% of the respondents) were women, and 27 of them (77%) had trained in psychiatric hospitals. Similarly, 33 (69%) of the 48 overseas graduates had been registrars in psychiatric hospitals. In contrast, 47 (51%) of the 93 male British graduates had trained in teaching hospitals or at the Maudsley Hospital.

The table gives the proportions of consultants who thought that they had had enough training in each area and that it had been adequately supervised and taught. The corresponding proportions in the three earlier surveys are also given. The 1963 survey covered consultants appointed from 1 October 1963 to 30 September 1966, the 1966 survey covered those appointed in the next three years, and the 1969 survey covered those appointed in the next three years, up to 30 September 1972. The present survey is called the 1972 survey.

When all the 24 areas of training were taken into account the Maudsley group reported the most satisfactory experience, while psychiatric hospital graduates reported the least. There were exceptions to this pattern, notably in psychogeriatrics, work with long-stay patients, and community psychiatry, but these were expected as the Bethlem and Maudsley hospitals have only recently taken on a district responsibility.

Although advances have been made compared with the first survey,¹ the figures in this survey were practically identical with those in the second and third inquiries.²⁻⁴ Indeed in community work and child psychiatry training seems to have got worse.

Discussion

Clearly the average newly appointed consultant has not had an adequate training in several important areas of psychiatry. The most disturbing lack is of experience in the community, as this is where most psychiatry will be practised in the future.⁷

TABLE 1—Numbers (and percentages) of consultants who said that training was adequate and adequately supervised. Results in present study are compared with those in three previous ones

Areas of psychiatry	Psychiatric hospital group (n = 95)	Teaching hospital group (n = 51)	Maudsley Hospital group (n = 18)	All 1972 (n = 164)	All 1969 (n = 125)	All 1966 (n = 108)	All 1963 (n = 148)
Psychogeriatrics	49 (52)	16 (31)	5 (28)	70 (43)	53 (42)	47 (44)	37 (25)
Long-stay patients	54 (57)	19 (37)	3 (17)	76 (46)	59 (47)	47 (44)	37 (25)
Rehabilitation	36 (38)	15 (29)	8 (44)	59 (36)	45 (36)	32 (30)	53 (36)
Individual psychotherapy	36 (38)	29 (57)	17 (94)	82 (50)	60 (48)	51 (47)	58 (39)
Group psychotherapy	35 (37)	26 (51)	15 (83)	76 (46)	53 (42)	44 (41)	36 (24)
Other methods of psychological treatment*	20 (21)	21 (41)	8 (44)	49 (30)	33 (26)	30 (28)	
Community work†	24 (25)	9 (18)	2 (11)	35 (21)	40 (32)	19 (18)	43 (29)
Subnormality	19 (20)	9 (18)	5 (28)	33 (20)	23 (18)	24 (22)	21 (14)
Child psychiatry	24 (25)	19 (37)	16 (89)	59 (36)	54 (43)	32 (30)	44 (30)
Forensic psychiatry	20 (21)	12 (23)	9 (50)	41 (25)	33 (26)	29 (27)	30 (20)
Epidemiology	25 (26)	26 (51)	14 (78)	65 (40)	41 (33)	32 (30)	
Administration	21 (22)	14 (28)	3 (17)	38 (23)	28 (22)	22 (20)	
Teaching	37 (39)	29 (56)	10 (58)	75 (46)	60 (48)	49 (45)	

*For example, behaviour therapy, hypnotherapy.

†In Part III accommodation, local authority day centres, and day hospitals.

The improvement hoped for in the *British Medical Journal* in 1973 has not as yet taken place.* Equally alarming is the lack of properly supervised experience with long-stay patients and in the psychiatry of the elderly.

The gap existing in 1971 between the most and the least privileged trainees still exists and is reflected in the pass rates in the MRCPsych examination.⁹

The best hope for an all-round improvement of training will come from the college's approval visits and the programmes of training (with inspection) proposed by the Joint Committee on Higher Psychiatric Training.¹⁰ The college has been making approval visits for only three years, so any resulting improvements would not have affected the consultants surveyed here, as most would have completed or nearly completed their training by the time the visits started. The next survey of consultants appointed between 1975-8 may include many people unaffected by any raising of standards because of their seniority, so that no overall progress may be shown, but if those appointed in the next two to five years fail to report any improvement then the value of approval visits and inspections will inevitably be questioned. Even so, some trainees, particularly overseas graduates and women, may demand the opportunity to spend some time in the more privileged centres to get better training and thus improve their performance in the membership ex-

amination. Perhaps the best way of satisfying this demand would be to introduce more rotational programmes including both teaching and psychiatric hospitals.

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In patients with neoplastic disease such as carcinoma of the prostate gland the serum urate level is often raised, especially if metastases are present. Is the use of allopurinol justified if there are no symptoms of hyperuricaemia? Would frequent estimations of serum urate level be of value in assessing the prognosis of neoplastic disease?

In patients with neoplastic disease the serum urate level may be raised when the rate of tumour cell breakdown is increased—for example, when a tumour has undergone necrosis of its centre due to outgrowing its blood supply or when the tumour has been treated with chemotherapy. On the other hand, hyperuricaemia may occur in association with renal damage due, perhaps, in this instance to an obstruction from the carcinoma of prostate. If severe hyperuricaemia occurs the patient should be treated with allopurinol and a high fluid intake. It is doubtful, however, whether frequent serum urate values would give any prognosis of a neoplastic disease beyond showing the rate of tumour cell breakdown.

A patient finds it impossible to have an erection and little semen is produced since a testicle was removed when a hernia was repaired. What treatment is suggested to correct these defects?

It is unusual to remove one testis for inguinal hernia repair in a man who is still sexually fully active. If this patient is over 65 then impotence is not uncommon, irrespective of the operation. Perhaps the

operation is now being blamed for the natural physiological failure of potency in old age, in which case no treatment is possible. If, for some reason, orchidectomy was performed in a younger man, then his impotence should be investigated to exclude diabetes and psychiatric disturbance. It is inconceivable that any neurological damage to the parasympathetic nerve supply could have occurred during surgery for an inguinal hernia, with the exception of the remote possibility of a retroperitoneal haematoma from a bleeding testicular artery. This possibility is a long shot and would certainly have produced symptoms postoperatively.

If there has been no reaction or complication to the first two doses of the pertussis portion of the triple dose is there any risk of the child reacting to the third vaccination? What degree of protection is there from the first two doses?

The condition of "no risk" does not exist for an immunisation any more than it does for any kind of medical treatment. If a child has not reacted adversely to two doses of vaccine, however, the chances of a serious reaction to a third dose must be negligible. Though two doses will provide some protection (the degree is impossible to estimate accurately), the main argument at this age is on a community rather than an individual level—maximum protection for young babies from a potentially fatal infection can be achieved only by full immunisation of all children.