Medical Education

Delivery of postgraduate medical education—who pays?

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Summary

As the cost of academic postgraduate medical education increases the DHSS may sometimes need to fund established academic posts or sessions within universities, and it must recognise the need for salaried sessional commitments by clinical tutors and encourage universities to integrate them more effectively into regional medical schools. Such activities will otherwise increasingly impose on undergraduate departments teaching demands that are neither practicable nor proper.

Introduction

In the present financial climate and with the need for further development greater clarification of the funding of postgraduate medical teaching is needed. I propose to describe the development of postgraduate training in psychiatry in one of the Thames regions and consider its possible relevance in terms of both funding and organisation for some other postgraduate disciplines and specialties.

Unlike the three other Thames regions, which each contain three or four undergraduate medical schools and one or more postgraduate institutes, the South-west Thames Region has only one medical school, St George's. Before NHS reorganisation there were four but only St George's had a professorial department of psychiatry. Academic departments of psychiatry in London are a relatively recent development, which has coincided with psychiatry emerging as an important and relevant undergraduate subject. They have been fully occupied with these undergraduate teaching demands. This department has restricted its postgraduate activities to its own rotational scheme for many years. For a London department it is relatively large but still comprises only one professor, two and seven-elevenths readers/senior lecturers, and one lecturer on its University Grants Committee-funded establishment.

Need for academic programme

As the only professor of psychiatry in the region and as the Royal College of Psychiatrists' adviser to the region, I found myself increasingly concerned with regional postgraduate training matters in psychiatry and, eventually, other specialties. About four years ago it became evident that the region needed a systematic "academic" programme for postgraduate education in psychiatry. There were a

few clinical tutors striving to raise educational standards, good occasional regional "crash" courses for the Diploma in Psychological Medicine (DPM), and a developing day-release course extending over two terms for part 1 of the new MRCPsych examination. The tutors ran these as well as providing local teaching: the honoraria were small and the academic rewards sometimes limited. As psychiatric work often suffers from being geographically separate from the rest of medicine the clinical tutors of psychiatry usually worked in isolated psychiatric hospitals remote from their other clinical tutor colleagues and the regional postgraduate centres.

Several problems and deficiencies were immediately evident. The clinical tutors, limited in number, had been appointed for their ability and enthusiasm regardless of the geography of the region (which extends wedgelike from the centre of London down to the south coast). They had developed a necessary and sturdy independence and were healthily wary of a professor who might interfere in their activities. They feared ivory-tower ideas would intrude and that another layer, this time of essentially undergraduate authority, would separate them from the University of London Postgraduate Medical Federation.

The new MRCPsych examination requiring three years' vocational training or its equivalent had begun to replace the old DPM examination, which required only two years' clinical psychiatric experience.

The calibre of postgraduate students was not always high. Many posts were occupied by overseas graduates and some supposed trainees in posts did not appear to want general or high learning in the new form.

Proposed programme

Five clinical tutors, I, and another senior member of the academic department formed a working party, which came to the following conclusions.

(1) The part 1 MRCPsych two-term day-a-week release course should continue to run at the same psychiatric hospital (Sutton) organised independently by one of the clinical tutors with realistic course fees and full secretarial back-up. Both clinicians and university basic medical science teachers would continue on a fee-for-lecture basis.

(2) A six-term day-release course should be planned covering the college syllabus for the part 2 final MRCPsych examination. Each term would comprise seven full days' study, accounting for 21 of the statutory 30 study-leave days available to each postgraduate student in a year. The course, aimed primarily at the 50 or so registrars thought to be in training in the region, should rotate around several psychiatric hospitals, with only about half of the days being spent at St George's. The hospitals were chosen because of their special relevance to the theme of the course on that particular day. There were great difficulties in choosing a day, and every psychiatric medical staff committee in the region was first consulted.

(3) Lecturers, either NHS or academic staff, were to be chosen to cover six lectures/seminars a day and invited on a fee-for-lecture basis. Organisers, usually one of ourselves, would be present throughout the day, often running the concluding seminar. As with the part 1 course there would be a free interchange of both teachers and organisers between the regional hospitals and the university department. It was also recognised that further secretarial help would be needed.

From the start the day-by-day organisation of this course was taken on by my senior academic colleague on the working party. He

was also appointed clinical tutor in psychiatry in the region. Realistic course fees (for which postgraduate students were reimbursed by the district as in the part 1 course) were calculated, and the cost of running the course was underwritten financially by the then regional authority, the now defunct South-west Metropolitan Regional Hospital Board.

(4) The occasional week-long and weekend concentrated residential courses preceding college examinations would continue, organised by the clinical tutors.

(5) Job descriptions for clinical tutors and also for a new category of psychiatric tutors were needed. The former would have regional courses and local area responsibilities, the latter would have responsibilities only within their psychiatric hospitals, each containing about 10 or fewer trainees (SHOs, registrars, and senior registrars) and receive an even smaller honorarium than the clinical tutors.

PSYCHOTHERAPY

It soon became evident that there was no way in which the important subspecialty, psychotherapy, either dynamic or behavioural, which is basic to much clinical practice and a requirement for the college as an aspect of general professional training, could be taught systematically and properly to the regional postgraduates. There were few consultants in these subjects in the region, and those at St George's were fully extended. Then, however, the Regional Health Authority (RHA) agreed to fund 16 consultant sessions through the medical school so that two people could be appointed at established senior lecturer level with the specific brief to teach and supervise postgraduates in psychotherapy throughout the region. Each of these posts was complemented by three NHS consultant sessions available in and rooted in the district division of psychiatry at St George's, thereby making each post full-time and providing the person in post with a clinical base.

These posts were filled about two years ago. The region not only funded the posts but provided finance for travelling expenses, for necessary equipment—such as portable videotape equipment—and for secretarial assistance. As might be expected the RHA sought some accountability through a series of reports on the work done.

These senior lecturers travel on average 645–800 km (400–500 miles) a month, sometimes bringing together trainees from more than one hospital and often committing a whole day to such visits. Such teaching and supervision needs to be accommodated within existing case conference times, lunch periods, and other times that postgraduates and their consultants can and are willing to make available. Because of the diplomacy, tenacity, and ability of the two people in post the system works fairly well, although some problems remain—rooted in timetable issues and occasional healthy local scepticism.

DAY-RELEASE COURSE

The day-release course was started in 1974 and has continued in the same form ever since. It is now in its second cycle. On the whole it works well but rapid turnover of registrar posts in the region is still a problem. Everyone cannot take advantage of what is intended to be a three-year course. On average about 20 to 30 students (mainly SHOs, some registrars, and others—90% from the South-west Thames Region) attend the part 1 course, and about 30 students (nearly all registrars from within the region) usually enrol each term for the part 2 course.

TRAINING POSTS

The district divisions of psychiatry within the region have encouraged their administrators to advertise training posts giving full information of the academic training facilities as well as the in-service training facilities available. This has not always happened because of the present NHS organisational communication problems and because of false economies sought by some administrators. Neither have optimal rotational schemes yet been worked out throughout the region. Meanwhile, a psychiatric subcommittee of the Regional Postgraduate Medical Committee has been formed comprising the original working group, the two senior lecturers in psychotherapy, the regional dean, and the regional specialist in community medicine concerned with medical staffing and postgraduate education.

DEGREE COURSES

It is now clear that some trainees would like to undertake research and some would like to work towards a research degree, most often an MD of their own university or an MPhil (London University). Most university regulations make this possible within a district hospital setting provided adequate supervision, instruction, and facilities are available, especially for the latter degree. For this and other reasons it may become necessary for at least some clinical tutors to become more fully attached to the medical school. Any such arrangement would need to transcend psychiatry and also apply to clinical tutors in other fields. Perhaps at first only those interested and appropriately qualified might be invited to become honorary senior lecturers in the relevant school and thus be represented on the academic board of that school. So far as London University is concerned they would also thereby become eligible for consideration for appointment as recognised teachers in the university. The relevance of this would be (a) to set appropriate academic standards for their posts; (b) for them to have a small but significant voice in the faculty of medicine matters in their region within the undergraduate school and give them closer links with the relevant academic department and with other medical school resources; and (c) to allow them to supervise a wider range of research degrees.

Funding the scheme

The specific funding for postgraduate teaching in psychiatry by the RHA for 1976–7 may be seen in the table. Such specific expenditure is the tip of the iceberg of the more general cost of postgraduate vocational training in psychiatry. Thus every consultant working in the region and especially in the teaching hospital(s) with an SHO/registrar/senior registrar in in-service training is expected to spend some time each week talking with the trainee and supervising his work. Moreover, the full-time salaries of the trainees include payment for such training experience as well as covering the contractual 30 days' study-leave a year and time for in-service research. A proportion of capital and recurrent expenditure concerning general postgraduate medical centres and educational aids may also be legitimately allocated to the needs of psychiatry.

TABLE—Current specific funding for postgraduate teaching in psychiatry by the RHA in 1976–7. Percentage costed in respect of attenders from South-west Thames Region in parentheses

MRCPsych courses:	£
Part 1 (90% of total)	1400
Part 2 (90% of total)	1650
Concentrated residential courses (30% of total)	3600
Honoraria to six clinical tutors (including one in mental handicap)	3000
Secretarial salaries	6100
Honoraria to seven psychiatric tutors	875
Senior lecturer salaries (16 sessions plus superannuation, etc)	14600
Specific supporting expenses	4200
Total	35425

Discussion

I have described these developments in the hope that they may clarify some of the issues now concerning many people who organise regional postgraduate medical training programmes. In other regions and in other specialties such teaching may be more advanced. The present model, however, contains some unusual elements and implications.

The advantages of the region funding senior academic posts for specialised postgraduate teaching by linking such posts to the medical school are evident, but they leave the university, in this case the local professor of psychiatry, accountable to the region for the proper development of the posts. Not all specialties lend themselves to such arrangements. Even with three sessions a week spent in the teaching hospital there is insufficient time for the senior lecturer to have an effective clinical bed base unless he is well backed up by others. The peripatetic nature of the work probably means that it is most appropriate for highly specialised subjects when the senior lecturers have little responsibility for beds; perhaps aspects of anaesthesia, radiology, pathology, etc. Meanwhile, I think it would be quite wrong for an undergraduate department nowadays to give more than a

small fraction of the university resources earmarked for undergraduates and research to postgraduate education aimed specifically at acquiring professional diplomas.

The proposal that clinical tutors in the non-teaching hospitals in the region should be more actively engaged in the affairs of their local medical school may entail some universities amending their regulations to accommodate such a development. It can be accomplished only provided academic standards are maintained in the process and at the same time undergraduate schools do not find themselves swamped or threatened with being swamped by postgraduate teachers, perhaps representing a few specialties that are particularly active in the postgraduate training field. An effective but acceptable system of representation on academic boards is needed.

General training programmes vary in length between the specialties. In psychiatry it is currently three years. If a trainee is to experience the full regional course described above he will need to be in approved rotational posts within the region for three and a half years, say one year as an SHO with promotion to registrar for two and a half years. While this system operates in our own department it does not operate throughout the region. Flexibility in appointment and re-appointment and perhaps redefinition of some contracts are needed to accommodate the training needs of various specialties.

If registrars and senior registrars are to undertake more research work as part of their training programmes (and this is highly desirable since clinical practice is clinical research and everyone should know the ground rules) this will require more supervisory time and will have further staffing implications. Not all specialties lend themselves to in-service research so readily as others, but in most there are several relevant master and doctorate degrees. Clinical tutors may sometimes be or come to be appropriate supervisors, but at the moment they are paid

very little and their clinical duties are not always adequately reduced during their period of office. Greater recognition of their role in terms of both time and money, including recognised sessional commitments, is probably now necessary.

At present the South-west Thames Regional Health Authority is contributing over £35 000 a year specifically to the more formal aspects of postgraduate medical training in psychiatry in its region. I have suggested some ways in which more than this needs to be spent in the immediate future. It may be that other regions are currently committed in various ways to the same extent or even more heavily. Meanwhile, even if the present unexpanded system described (uncomplicated by the much greater costs of in-service training) was uniformly applied to other specialties and all regions nationally and regionally, designated DHSS funds will be needed.

Finally, can one evaluate the impact of the expenditure of so much time and effort? An impression is gained easily enough and there are the college examination results to go by, but there are numerous variables impinging on the process. Now is the time, however, to set up some long-term attempt at evaluation, preferably inspired centrally by the need to fund the total federal exercise and the opportunity that this presents.

The above developments have been possible only because of the wholehearted collaboration and hard work of many people, particularly Dr E S Paykel, reader in psychiatry, St George's Hospital Medical School, and the clinical tutors in the region in 1973 and thereafter—namely, Dr J A Birtchnell, Dr A A Black, Dr E G Lucas, Dr J S Stead, and Dr E D West. Professor G W A Dick, the regional postgraduate dean, has been a constant source of real support and guidance. Dr M A Fawkes, regional specialist in community medicine, South-west Thames Regional Health Authority, has been especially helpful.

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Outside Europe

Lassa fever in Panguma Hospital, Sierra Leone, 1973-6

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Lassa fever is an acute febrile disease of man caused by a virus belonging to the arenavirus group. Since Lassa fever was first described in 1969 outbreaks of varying size and severity have occurred in Nigeria, Liberia, and Sierra Leone.¹⁻⁵ The outbreak in Sierra Leone came to light because Lassa fever was diagnosed in London in a patient from Panguma.⁶

We analysed the records of 156 patients admitted to Panguma Hospital, Sierra Leone, from January 1973 to March 1976 with a diagnosis of Lassa fever and reviewed the clinical and

epidemiological features of the disease in this area. We have also included some data from Segbwema on 108 patients admitted with Lassa fever to the Nixon Memorial Hospital in 1975.

Panguma Hospital

The patients (all Africans) were admitted to hospital from the overcrowded general outpatient clinic, where patients with infectious disease cannot be isolated. Some were admitted direct to a four-bed isolation ward, but about 40% were initially barrier nursed in the general ward before being transferred to the isolation ward. Medical personnel only occasionally wore gowns, gloves, and masks and visitors never did so. Clinical examinations were conducted daily. Laboratory tests were carried out in the main hospital laboratory, no special precautions being taken.

Blood samples were obtained with a syringe and the serum stored in a refrigerator at 4°C until serological tests could be carried out by complement fixation (CF) or fluorescent antibody techniques. The diagnosis was confirmed serologically in 40 of the 156 Panguma patients and 11 of the 108 patients in Segbwema.

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