MEDICAL PRACTICE

*Medical Education***General professional training in psychiatry in the South-west Thames Region**

JOHN S STEAD, GEORGE W A DICK, ARTHUR H CRISP, RONALD S VINER

General professional training in psychiatry usually requires a minimum of three years' in-service training in senior house officer and registrar posts, leading to membership of the Royal College of Psychiatrists (MRCPsych) by examination.

In 1974 the postgraduate dean of this region and his adviser from the Royal College of Psychiatrists set up a psychiatric subcommittee of the regional postgraduate medical committee, to consider and advise on the planning of training in psychiatry in the region. At that time, four clinical tutors ran well-known weekend and week-long block release courses which took place every six months, either at Brookwood psychiatric hospital or at the University of Surrey, in addition to their local teaching responsibilities. These courses were intended to prepare candidates for the professional examination, which occurred twice yearly. In addition one of the tutors had organised a two-term day release basic medical science course for Part A of the Diploma of Psychological Medicine (which became also suitable for the preliminary MRCPsych examination).

Early on, the subcommittee recommended the setting up of a regional two-year day release course (consisting of six seven-week terms), which was designed to equip candidates for the final part of the MRCPsych examination. After two years the entire course was held at St George's Hospital Medical

School. Another development was the appointment of two peripatetic senior lecturers in psychotherapy¹ and subsequently a senior lecturer in child psychiatry and a professor in the psychiatry of mental handicap—all with special regional responsibilities for postgraduate training. Furthermore, additional clinical and psychiatric tutors were appointed throughout the region. One of them was responsible for the administration of the MRCPsych Part 2 course, while others continued to be responsible for the six-monthly block-release courses, but the main responsibilities of these tutors were to improve training within their own hospitals and to encourage attendance at regional courses and the conduct of research.

The psychiatric subcommittee also gave priority to programmes encouraging the setting up of rotational training, and it soon recognised that there were particular difficulties in incorporating posts in mental handicap hospitals into such schemes.

An attempt was also made to monitor the progress of trainees: tutors were encouraged to report on this regularly to the subcommittee and the postgraduate dean visited all hospitals annually and met as many trainees as possible. There were about 80 registrars in psychiatry and mental handicap in the region, but the record was not up to date. The development of a computer-based records system for all trainees in the region, which is held in the office of the postgraduate dean, has remedied the situation. The data on senior registrars and registrars are obtained from the application forms, the job descriptions, and the contracts for each post. Information regarding senior house officers is sometimes difficult to obtain but is now nearly complete.

Situation in 1979

Of the total pool of registrars, the numbers attending the MRCPsych Part 2 course between 1974 and 1979 were 22,

Lady Chichester Hospital, Hove, Sussex

JOHN S STEAD, MD, FRCPSYCH, regional adviser in psychiatry, South-west Thames Region

British Postgraduate Medical Federation, London NW1

GEORGE W A DICK, DSC, FRCP, postgraduate dean, South-west Thames Region

RONALD S VINER, records coordinator, South-west Thames Region

St George's Hospital Medical School, London SW17

ARTHUR H CRISP, MD, FRCPSYCH, professor of psychiatry

23, 27, 21, and 22. Since the course lasts for two years, the total number of postgraduate students attending has been something over half of the total, say, about 70. Nevertheless, the peripatetic senior lecturers in psychotherapy meet far more registrars than this and, for instance, in 1978-9 they were regularly teaching 65 of them. Another factor that has tended to raise educational standards during the past five years has been the visits of the approval teams of the Royal College of Psychiatrists to all psychiatric hospitals in the region. They have assessed the training facilities at each hospital, and the majority of them are now approved.

Despite all these efforts it had become abundantly clear by 1979 that most registrars were not seriously engaged in training. The regional postgraduate medical committee therefore asked the dean and the regional adviser in psychiatry to interview as many of the registrars as possible, to report on their training, and to try to evaluate its effectiveness. In the summer of 1979 two of us (GD and JSS) visited the department of psychiatry at St George's Hospital, 11 psychiatric hospitals in the region, and six hospitals for the mentally handicapped. Before these visits a questionnaire was sent to each registrar to be collected at the time of the visit, and another questionnaire was completed at the time of the interview. Each tutor also completed a questionnaire outlining the training programme in his hospital. This paper presents analyses of some of the data collected in that study.

Results and comments

NUMBERS OF REGISTRARS

Table I gives the establishment in whole-time equivalents (WTE) and the WTE per 100 000 population of consultants, senior registrars, and registrars in the SW Thames region compared with that of England and Wales. The exact position is complicated by the fact that the DHSS figures for the region use a population figure of 2 855 200, whereas the actual catchment populations for the mental illness and mental handicap hospitals (from population figures supplied by management services division of the SW Thames RHA) are 3 164 400 and 3 445 700 respectively. Using these latter population figures and the DHSS WTE per 100 000 for England and Wales, the expected regional WTE establishment of registrar posts in mental illness is 40.82, which leaves a surplus of 32 posts, and for mental handicap it is 2.41, which leaves a surplus of 8.50 posts.

AGE AND SEX DISTRIBUTION

The age distribution of 80 registrars (56 men and 24 women) was widely scattered (table II). The average age for men and for

women registrars was 34.5 years, but if the three male registrars aged over 50 are excluded, the male average age is reduced to 33.5. Comparison of the average age of registrars in various specialties (figure) shows that psychiatry has the highest.

Comparison of average age of registrars in psychiatry with some other specialties.

YEARS IN POST

Most psychiatric registrars have been senior house officers in the specialty for at least one year before being appointed as registrars. In the SW Thames Region appointments to registrar posts are usually approved for three years, although an extension for a fourth year may be allowed to complete parts of the training or to achieve a postgraduate qualification. Our survey showed that 17 out of 73 of the registrars had been in that grade in Britain for over four years and 14 for over six years. Those with the longest tenure were all overseas doctors, many of whom had also worked in the specialty before coming to Britain. Moreover, a considerable number of trainees, particularly those from overseas, who had repeatedly failed to attain the MRCPsych or DPM had occupied successive psychiatric registrar posts by moving from region to region.

COUNTRY OF PRIMARY MEDICAL DEGREE

Four-fifths of the psychiatric registrars in the region are overseas graduates (tables III and IV), a much higher proportion than those for other specialties in the region.

ASPIRATIONS OF REGISTRARS

Although we appreciated the pitfalls of the question, we asked the registrars: "What work do you hope to be doing in 10 years' time?" The replies are shown in table V.

Twenty-five of 71 registrars stated that they hoped to become consultants in Britain: 15 of the total were UK graduates, and most of these were postgraduate students of high calibre in the two teaching hospital rotational schemes. Of the overseas graduates, we were impressed by those from Sri Lanka, almost all of whom appeared likely to obtain consultant posts in their own country. Many of the remainder who hoped to become consultant psychiatrists in Britain had clearly little chance of ever achieving their ambition. A considerable number had come here to work in another specialty but having failed to establish themselves in it had changed to psychiatry in which specialty jobs were relatively easy to get. Some women doctors from overseas had found jobs in psychiatric hospitals to be close to their husbands who were working in other specialties.

IN-SERVICE AND LOCAL TRAINING

In many of the hospitals there were excellent teaching programmes, organised and run by the tutors. While most consultants were ap-

MINIPRINT TABLES I-V

Table I—Registrar establishments in mental illness and mental handicap in the South-West Thames Region in relation to national norms

Grade	England & Wales		SW Thames	
	establishment	WTE per 100 000	establishment	WTE per 100 000
Mental illness	1011.20	2.06	73.50	2.54
Consultant	221.00	0.45	16.00	0.56
Senior registrar	611.50	1.29	65.70	2.30
Registrar	177.80	0.36	20.70	0.73
Mental handicap	12.50	0.07	4.80	0.16
Consultant	36.50	0.07	12.30	0.43

All figures from DHSS WTE tables 30.9.78.
*Establishment figure for registrars includes staff in post only.

IIm

Table II—Ages of registrars

Age (yr)	Men		Women
	Number	%	Number
26-29	11	4	4
30-34	16	6	6
35-39	17	9	3
40-44	11	3	1
45-49	1	0	0
Total	56	24	

IIIm

Table III—UK and non-UK graduates in registrar grade—South-West Thames Region as at 13 November 1979

Specialty	% UK	% Non-UK
Medical specialties	61	37
Obstetrics and gynaecology	31	69
Pathology	41	59
Radiology	41	59
Psychiatry (including mental handicap)	21	79
Surgical specialties	45	55
Anaesthetics	38	62

IVm

Table IV—Countries of graduation

Country	Men		Women	Total
	Number	%	Number	%
Britain	10	8	18	UK
New Zealand	1	1	3	Old Commonwealth
South Africa	2	2	4	
India	14	2	36	Indian subcontinent
Sri Lanka	12	4		
Pakistan	2	2		
Bangladesh	2	2		
Others*	14	2	16	
Total non-UK			55	

*Two men each from Egypt, Iran, and Switzerland, one man each from Burma, Ceylon, Iraq, Italy, Lebanon, Malaya, Sudan, and Uganda, and one woman each from Chile and Czechoslovakia.

Vm

Table V—Aspirations of registrars

Aspirations	UK graduate		Non-UK graduate		Total
	M	F	M	F	
Consultant UK	9	6	8	2	25
Consultant elsewhere	1	1	23	5	30
Medical staff or clinical assistant or equivalent abroad	1	1	1	1	4
Private psychiatrist abroad	1	1	1	1	4
GP UK	4	1	1	1	7
GP abroad	1	1	1	1	4
"Health Admin" abroad	1	1	1	1	4
Research UK	1	1	1	1	4
"Depends on husband"	1	1	1	1	4
"Don't know"	1	1	1	1	4
Totals	10	8	41	12	71

parently willing to take part occasionally in formal lecturing if requested, contrary to our expectation, many of them (according to the registrars' responses to the questionnaire and interview) did not engage in day-to-day in-service training of their juniors.

MENTAL HANDICAP

None of the registrars whom we interviewed in hospitals for the mentally handicapped intended to pursue a career in the psychiatry of mental handicap.

Discussion

Clearly in the SW Thames Region most registrars in psychiatry neither intend to engage in, nor are suitable for, professional training in psychiatry with a view to obtaining a post as a consultant psychiatrist. It was evident from the dean's visits over the years and from this systematic survey that the calibre of some of the registrars working in these hospitals was a cause for concern. Many seemed to have drifted from hospital to hospital and from discipline to discipline with no career objective, and they appeared to be employed essentially for service duties without participating in training of any kind and despite the extensive educational programmes available in this region. This finding also has to be set against the obvious excess of registrar posts, particularly in this region. It was quite evident that with their many responsibilities and heavy case loads that without the service contribution from these registrars, which was not infrequently restricted mainly to medical care and on-call duties, many consultants would have been unable to cope.

We are not certain how universal are the problems that we have found in the SW Thames Region. Since the reorganisation of the Health Service in 1974 an effort has been made to ensure that the postgraduate dean or his representative (usually a tutor) has been present at all registrar appointment committees to make certain that proper academic standards were applied (though this has often not been possible because of overriding service requirements and the poor calibre of applicants who have been applying). It might be appropriate to consider whether these appointments should not carry the absolute requirement to enrol for general professional training (that is, to register on an appropriate regional course) and for the employing authority similarly to agree to reimburse fees. As a general rule when appointing registrars, it is not appropriate to appoint doctors who have been qualified for very many years, who have already spent more than five years in psychiatry in the registrar grade, or who have frequently failed the professional examination.

In our view the situation would be healthier if the number of registrar posts were radically reduced in the region—say halved—with the reallocation of some posts so as to establish the very best rotations. Thus more rotational training posts are needed in such subjects as drug dependency, forensic psychiatry, behavioural/dynamic psychotherapy, and child psychiatry. These rotations would provide the proper breadth of service experience and would require comprehensive supervision and formal training for those in post. The present model in the teaching hospital is to appoint doctors to senior house officer posts for about 12 months with the prospect of promotion to registrar grades for two and a half years, allowing them thereby sufficient time to obtain the membership of the Royal College of Psychiatrists.

The number of registrar posts in mental handicap should probably be reduced to about five, thereby allowing general professional trainees in the region to spend six months in such a post.

The relocation of some of the training posts, probably to the teaching hospital, would require some additional expenditure, but not much, since the funds deriving from the many discontinued registrar posts could then be made available for the

employment of clinical assistants or hospital practitioners in the psychiatric hospitals.

A minority of overseas graduates in some of these training posts are concerned to complete their general professional training and then return to their country of origin. But does their present work and training equip them for this?

Insofar as overseas graduates continue to come to Britain seeking general professional training before returning home, thought should be given to mounting courses specific to their needs. Certain models are available for this—for instance, the one recently established by the University of London (and involving one of us (AHC) in his capacity as medical faculty dean) which provides postgraduate training facilities, mainly in medicine, surgery, and pathology, for certain overseas graduates and which allows academically supervised use of the widespread training facilities round and about London, including posts within and outside professorial units. These training programmes are geared to the acquisition of the appropriate postgraduate diplomas and skills relevant to practise in the country of origin. Such supernumerary trainees bring with them not only their salaries but also course fees.

Requests for reprints to: Professor A H Crisp.

Reference

- 1 Crisp AH. Delivery of postgraduate medical education—who pays? *Br Med J* 1977;i:1397-9.

(Accepted 18 August 1980)

What are the investigations and treatment of spontaneous cerebrospinal fluid rhinorrhoea in an otherwise healthy person?

I would question whether the term "spontaneous" cerebrospinal fluid rhinorrhoea is ever correct. There is always a cause. Probably the commonest is an old head injury—therefore the history is all important. Rhinorrhoea may occur a few days after an injury, during convalescence, or at any time up to months or years. Soon after the injury an established fistula draining cerebrospinal fluid may be blocked by a mucus plug, air bubble, or blood clot. This then gets cleared by an alteration in intracranial pressure, such as coughing or straining or by break up of the clot, and the cerebrospinal fluid drains again. Why this condition occurs years after a head injury is not clear but may be due to scar tissue widening a pre-existing but very narrow fistula that has passed unnoticed or sometimes to necrosis of bone, particularly in the area of the cribriform plate or the roof of the frontal sinus. A long-standing deficient blood supply could cause necrosis of the bone. Clearly, other causes might be a chronic infection or local neoplastic condition.

First of all it is important to establish that it really is cerebrospinal fluid rhinorrhoea by measuring the glucose in the fluid, which will match that of the cerebrospinal fluid, but it will have no glucose in it if it is a local secretion of watery mucus. The other means of detecting whether it is cerebrospinal fluid is to do a lumbar puncture and insert some dye, such as methylene blue or carmine red, that will come out through the nose and may be seen. It is also possible to use radioactive albumin, which again can be monitored in the nasal secretions. If the fluid is seen to be coming from above the middle turbinate the fistula almost certainly will pass through the ethmoid or sphenoidal air cells. If it comes from beneath the anterior end of the middle turbinate the fistula is more anteriorly placed and is likely to pass through the frontal sinuses. The investigations therefore must take in these possible causes. They should include an examination of the nose and the sinuses and direct and indirect techniques including radiology and tomography, and biopsies to exclude neoplasia and other low-grade infections. There may be evidence of an old fracture through the base of the skull from an unrecorded, quite severe head injury. Treatment will depend on the cause, once established. Essentially, the fistula must be sealed. Nowadays it is more common to use an intradural approach as this provides a more sterile field. Tissues such as little bits of muscle are used to block the fistula. This is a job for a competent neurosurgeon.