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Are psychiatrists real doctors? A survey of the medical experience and training of psychiatric trainees in the west of Scotland

AIMS AND METHOD

A questionnaire was sent to 122 psychiatric trainees in the west of Scotland to clarify the extent to which trainees provide physical healthcare to their in-patients and to establish trainees' views on the need for further training.

RESULTS

Almost all of the 65 respondents were expected to provide emergency care, and a large majority dealt with physical health problems on a regular basis. Few respondents had received any formal training in physical health care problems since entering psychiatry.

CLINICAL IMPLICATIONS

The results of the questionnaire suggest that psychiatric trainees are currently providing a considerable amount of physical healthcare for psychiatric in-patients. Clarifying the medical experiences and training of psychiatric trainees may help to inform future debate as to the appropriate management of physical healthcare for psychiatric patients.

For years it has been recognised that there is an association between poor mental health and poor physical health. Patients with mental health problems are more likely than the general population to have physical health problems (Goldman, 1999) and are known to have an increased mortality rate (Harris & Barraclough, 1998). There are concerns that it can be difficult for people with poor mental health to receive good physical healthcare (Phelan *et al*, 2001), and also that poor physical health can interact with and even worsen mental health (Kupfer & Frank, 2003; Ward *et al*, 2003).

It remains a matter of debate as to whether it is for psychiatrists to manage physical health problems (Shore, 1996; Fink, 1997; Klusman, 2001). On the one hand, the psychiatrist is often ideally placed to screen for and manage physical problems; indeed, the psychiatrist may be the only point of contact with health services for some patients. On the other hand, without further training or experience, psychiatrists may not necessarily provide the best care for patients (Rigby & Oswald, 1987), and care might be better delegated to other health care professionals with an appropriate medical background – in particular, the primary care health team (National Institute for Clinical Excellence, 2002; Welthagen *et al*, 2004).

In general, psychiatric trainees at the senior house officer level are responsible for the physical healthcare of all in-patients under their care. The Royal College of Psychiatrists provides comprehensive guidelines and learning objectives specifying training requirements in psychiatric disease. In contrast, there are few references to the role of the psychiatric trainee in assessing and treating physical health problems.

At present, discussion as to whether psychiatric trainees should provide physical healthcare for psychiatric in-patients is limited by a lack of information. This paper reports the results of a questionnaire that was sent to psychiatric trainees in the west of Scotland. The aim of the questionnaire was to clarify the amount of physical care that was being provided from day to day by

psychiatric trainees, further medical training received, medical experience prior to commencing psychiatric training, and trainees' attitudes towards the provision of physical healthcare.

Method

A questionnaire was sent out to 122 trainee psychiatrists in the west of Scotland, together with a brief letter of explanation. No time limit was set for the return of the questionnaires. The questionnaires were identified by the individual training scheme, but respondents were not asked to give their names.

Results

A total of 65 questionnaires were returned over a period of 3 months, giving a response rate of 53%. Each questionnaire item was answered by between 62 and 65 respondents. On average, trainees had been working in psychiatry for 19 months. Over half of the doctors were working in general adult psychiatry, but there were responses from all of the major psychiatric sub-specialties. Questionnaires were returned from all nine of the training schemes in the west of Scotland, potentially including 20 different hospitals.

Emergency care

Emergency care was described as that given for 'situations in which a failure to act immediately/in the next 10 minutes would potentially be life-threatening'. Sixty-three psychiatric trainees (97%) answered that they were expected to provide emergency care, and 60 (92%) that they would be expected to supervise a cardiac arrest. Since starting their training, 19 (30%) doctors had never actually provided emergency care, but 40 (63%) had provided care between one and five times, and 5 (8%)



more than five times. On average, emergency care had been provided 1.5 times per year.

Non-emergency medical provision for in-patients

Under normal circumstances, almost all the doctors (63 out of 65) would perform a physical examination on all patients who were admitted to hospital. The majority of doctors would request blood tests one or more times a week, and 59 (95%) replied that they were expected to interpret and act on the results of these blood tests independently.

Routine general practitioner (GP) type problems were defined as 'for example, sore throat, cough, stomach ache, temperature, rashes, pain, high blood pressure, abnormal blood results, falls or injury on the ward'. Only a minority of doctors (8 doctors; 13%) would not expect to review such problems during a regular nine-to-five day, and even fewer (2) during a weekend shift on call. The remaining doctors reported that they were being asked to review patients with 'routine GP-type problems' approximately 2.4 times during an average nine-to-five day, and 3.1 times during a weekend shift on call.

Long-term healthcare was defined as 'for example, blood pressure monitoring, testing for diabetes/high cholesterol, advice about smoking and obesity, cervical screening and breast screening'. Half of the doctors ($n=31$) believed that they were expected to provide long-term healthcare for their in-patients.

Training

Since commencing their psychiatric training, over 90% of the respondents had received no further training in 'GP-type problems', long-term healthcare problems, performing physical examinations, or in the interpretation of blood results. More than a third (24 of 62; 38.7%) had not had any training in emergency care, but the remainder had had further training at least once. Only 5 (8%) doctors made no attempt to keep their general medical skills up to date themselves; the majority either making a regular effort to update their knowledge, or reading around as they encountered clinical problems.

Medical experience prior to becoming a psychiatric trainee

Twenty-two doctors had gone straight from pre-registration jobs into a psychiatric rotation. The remaining 38 (63%) had worked an average of 23.5 months (ranging from 6 months to 6.5 years) in a wide variety of jobs, including most medical specialties, accident and emergency, obstetrics and gynaecology, surgery and general practice (both GP registrar and actual GP posts). Only a handful of doctors had gained qualifications in other specialties before entering psychiatry.

Attitudes to the management of physical health problems

Respondents were asked whether they felt that psychiatrists at a basic specialist training level should be competent to deal with a range of physical health problems, and whether they should receive further training in those areas. Their responses are given in Table 1.

Discussion

In general, psychiatric trainees appear to be providing a considerable amount of physical healthcare for their patients. Almost all of the trainee psychiatrists who responded to the questionnaire were expected to deal with routine general practitioner-type problems on a regular basis; if not during their nine-to-five day, then while on call. The overwhelming majority of trainee psychiatrists were expected to provide emergency care, and although medical emergencies are rare in psychiatric hospitals, it is likely that doctors would have had to provide emergency care on at least one occasion during their training.

With the exception of emergency care, the majority of psychiatric trainees are not receiving formal training in physical healthcare. Most trainees in our study reported that they made some independent attempt to keep their medical skills up to date, although this might not

Table 1. Trainees' attitudes to the provision of physical healthcare to psychiatric patients

Area of competency	Do you feel that psychiatric trainees should be competent in the following areas?			Number of respondents	Do you feel that psychiatric trainees should receive further training in the following areas?			Number of respondents
	Yes	Unsure	No		Yes	Unsure	No	
Emergency situations	61	1	1	63	62	1	0	63
GP-type problems	46	12	6	64	42	13	7	62
Long-term healthcare	29	16	18	63	35	10	18	63
Standard physical examination	63	0	0	63	42	7	14	63
'Psychiatric' medical problems	61	2	0	63	62	0	1	63
Non-'psychiatric' medical problems	59	2	1	62	47	7	9	63

GP, general practitioner.

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necessarily be a true reflection of actual practice. A large proportion of psychiatric trainees have considerable experience in other fields of medicine before entering psychiatry, and this would need to be taken into consideration if further training were planned.

Although the overall response rate was only 53%, this was biased by the extremely low response from two of the larger training schemes. The questionnaire was sent out to trainees in a single area of Scotland only, but there is no reason to suspect that the results would not generalise to other regions. The questionnaire was designed and targeted around the job of the senior house officer because it was felt that they are largely responsible for the provisions of healthcare on the hospital wards. Only three respondents (5%) said there was 'somebody with a medical background specifically employed for [the] purpose' of overseeing the long-term health of their patients, and there were no other comments or responses to suggest that staff other than the senior house officer looked after emergency or routine medical enquiries. Indeed, just five psychiatric trainees (8%) replied that they would ask their consultant or registrar for help in an emergency, and only two (3%) would ask for advice on non-urgent physical healthcare problems.

This study does not pretend to answer the question whether it is appropriate for psychiatrists to manage physical health problems. However, its results do suggest that psychiatric trainees are currently providing a considerable amount of physical healthcare for psychiatric in-patients in their charge. At present, this provision appears to be largely unsupervised by their consultants, and is in the absence of further training. Although not admitted to hospital for management of their physical health, psychiatric patients have high rates of medical comorbidity, and it would seem particularly important to ensure adequate physical healthcare provision for them. Perhaps it is time to ask whether the current provision is in fact adequate.

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Declaration of interest

None.

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