

Training in adult general psychiatry

SpRs in cloud cuckoo land

Martin Deahl and Trevor Turner

So who wants to be a general adult psychiatrist? The service is under seige, consultant vacancies are escalating and the 1996 figure, quoted by John Milton in his paper (pp.345–347, this issue), almost certainly underestimates the current short-fall. Low morale due to an escalating workload, poor relations with managers and a lack of time for Continuing Professional Development (CPD) all contribute to the present crisis (Royal College of Psychiatrists, 1992, 1996). The inquiry 'blame' culture, the untested and bureaucratic formalities of the Care Programme Approach, and the dialectic between fundholding general practitioners *v.* the Department of Health ('my patients' *v.* 'severe mental illness') magnify the sense of stress. Newly appointed consultants experience less direct patient contact than they had anticipated and have 'job plans' which may be at best vague and a worst totally unrealistic, with wide variations in workload (Audit Commission, 1995, Creed, 1995). Most insidious has been the impact of the *Patient's Charter* (1997), with such phrases as "you can expect" and "you have the right". Patients can "expect to receive a visit" by appointment "on the day you ask for it if you give more than 48 hours notice", and within four hours following an urgent referral. *Parri passu* there is no responsibility on the patient, for example, to attend an out-patient appointment (did not attend rates often exceed 20%) or to treat medical and nursing staff with courtesy or respect. It is not surprising that trainees look askance at the role of their seniors and elect to seek dual accreditation for a sub-speciality providing an 'escape route' if the present situation persists.

Current specialist registrar (SpR) training may be well structured but should it protect trainees from the day-to-day difficulties to the consultant? College regulations mean a SpR may spend only six sessions in their clinical attachment, and they are meant to be 'supernumary' to service requirements. The SpR certainly needs protected time for study, teaching and research, if they can do it, but we wonder how much research is actually published? The average SpR should, by our calculations (assuming 46 work-

ing weeks per year), have spent 138 days in research after three years. Is that going to help them manage an acute admission ward, make fine decisions concerning risk management or the use of the Mental Health Act, and most importantly learn about how to cope with these pressures? Working without boundaries lies at the heart of general psychiatry. Learning to absorb the transference of society's most disorganised members requires experience, good training and confidence in that training. There are strengths of the traditional apprenticeship, and the notion of a 'hands on' final year makes sense.

General adult psychiatry remains the cornerstone of the mental health service. It must be nurtured by a combination of limited catchment area, realistic job-plans and sufficient time out in the form of CPD and sabbaticals. The boundaries of general psychiatry must be defined and acknowledged by managers and society. We cannot go on taking limitless responsibility for the untreatable and unwanted (Deahl & Turner, 1997). Many early retired or independent sector consultants leave not for financial gain, but because they merely wish to get on with seeing patients and can no longer tolerate the paperwork, administrative demands and endless meetings. The retreat into 'chambers', working on an item of service basis, against our instinctive National Health Service loyalty, grows ever more tempting.

Although general psychiatry must get its house in order, SpRs too need to appreciate that their time at that grade is but a brief journey. It takes several years to realise yourself in the consultant role. To change habits, from just managing this admission or that case, to managing someone else managing it and thinking of the patient's illness or lifestyle over several years, takes time in post. Doctors are used to seeing rapid results of their treatment, days or weeks at most, but taking initiatives whether clinical or organisational, that will only bear fruit in several years, can seem unstructured and wishy-washy. Training has been increasingly dismembered into specific tasks: diagnosis, treatment protocols, risk assessments, etc., but where does the

trainee learn to play the role of the consultant psychiatrist? Because it is a role, a form of subtle theatre that gets the timing right for exits and entrances, prompts people in their lines and knows there is always an edge of anarchy. Ring-fencing may be good for mental health funds, but doing it to training time and divorcing training from service is unrealistic, unreasonable and unfair for the trainees.

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*Martin Deahl, Consultant and Senior Lecturer in Psychological Medicine, and Trevor Turner, Consultant Psychiatrist, Department of Psychological Medicine, St Bartholomew's Hospital, West Smithfield, London EC1A 7BE

*Correspondence

The Royal College of Psychiatrists' *Journal of Continuing Professional Development*



Advances in Psychiatric Treatment
 Editor: Andrew Sims

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