Correspondence

Recruitment crisis – poor marketing or product failure?

I was interested to read Sekhri & Sibbett's expansion on the topic of recruitment problems in psychiatry.[1] They made a number of valid points and I look forward to the results of their proposed study of the opinions of foundation trainees. I was rather disappointed to see their letter conclude on the familiar note that the problem lies in a failure of marketing, or an 'underselling [of] psychiatry', which also seems to be the line taken by the Royal College of Psychiatrists with their campaign to promote psychiatry to medical and other students.[2] This is not a new approach. Instead of concluding that the problem lies in not getting the message out, should psychiatrists not be listening to the message coming in from trainees in the falling recruitment numbers, and overhauling the specialty?

Of the many factors discussed, the negative view of psychiatry from other medical professionals and other sectors of society such as the media surely has a corrosive effect on recruitment. A 'zero tolerance' approach to stigma has recently been proposed by the College,[3] although it remains to be seen how effective this will be at counteracting perceptions of psychiatry as a 'Cinderella specialty'. As Sekhri & Sibbett state, the 'separatedness' of psychiatry is likely compounded by the structural changes to health services. Most mental health services are run out of separate hospitals, and indeed separate trusts, from other medical specialties. In the post-asylum era of acute care it is not clear why this is of benefit to either patients or psychiatrists. One does not need to be a psychiatrist to know that stigma feeds on perceptions of separateness. Medical students and other doctors rarely see psychiatrists in grand rounds, in the doctors' mess or making rounds on other wards. Should we not now review whether such enforced separation of medical management of mental illness from medical management of physical illness is still justified?

There is general hope that more exposure to psychiatry during the foundation programme will increase the attractiveness of the specialty. We should also consider that the opposite may be true. The 'multidisciplinary' approach has taken a form and function in mental health such that it is now debatable whether even a consultant psychiatrist is the leader of clinical care, to a far greater degree than surgical or medical counterparts. There have been numerous reports extolling the demedicalisation of psychiatry[4] and a deskilling in fundamental aspects of psychiatric care such as psychopharmacology.[5] Also, whereas Sekhri & Sibbett draw attention to the heavy reliance of psychiatry on international medical graduates, a review of the pass marks for the College membership exams makes one wonder whether psychiatry has been successful in attracting doctors with the necessary linguistic, academic and clinical qualities required by such a demanding specialty. Accepting suboptimal candidates into psychiatry posts to maintain numbers may not be in the specialty's long-term interests, any more than it is in patients' interests. All of these factors may lead to a negative response from interested trainees on further exposure to the clinical realities of psychiatry.

A lack of sales is not always due to a failure of selling but can be caused by defects in the product itself. Rather than embarking on yet another marketing campaign, is it not time for the profession to listen to what trainees are saying and remake itself as a medical specialty fit for the 21st century?

1 Sekhri R, Sibbett R. Recruitment in psychiatry: a complex and multifactorial problem. *Psychiatrist* 2012; **36**: 118–9.

2 Psychiatry's identity crisis. *Lancet* 2012; **379**: 1274.

3 Jaques H. Royal college launches five year plan to increase applicants to psychiatry. *BMJ Careers* 2012; 27 Mar.

4 Lennox BR, Coles AJ, Vincent A. Antibody-mediated encephalitis: a treatable cause of schizophrenia. *Br J Psychiatry* 2012; **200**: 92–4.

5 Harrison PJ, Baldwin DS, Barnes TRE, Burns T, Ebmeier KP, Ferrier IN, *et al*. No psychiatry without psychopharmacology. *Br J Psychiatry* 2011; **199**: 263–5.

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Medical students' views of psychiatric teaching methods

Simmons & Wilkinson[1] demonstrated that medical students found cased-based discussion of child psychiatry more enjoyable and engaging than didactic lectures, with no reduction in exam performance. As the authors note, there is a dearth of studies comparing students' experience and enjoyment of different teaching methods in psychiatry. We welcome research of this nature as it may help us to improve the undergraduate experience of medical students in psychiatry.

We conducted a survey of two cohorts of students' (n=38) experiences of a 12-week undergraduate psychiatry rotation at a London teaching hospital. The programme consisted of grand rounds, in which students presented a case to the rest of the cohort and were marked by senior psychiatric trainees; web-based scenarios – online, problem-based cases with associated questions which students completed themselves and then were taught around the topic by junior psychiatric trainees; a series of seminars delivered by consultants and senior trainees; and firm clinical teaching including weekly tutorials by consultants.

The survey showed that on a range of 1 (very poor) to 5 (excellent), grand rounds received the highest average rating (4.1), followed by web-based scenarios (3.9), seminars (3.7) and finally firm teaching (3.6). Free-text responses showed that incorporating role-play style teaching into sessions was seen as particularly useful and students wanted more teaching delivered in this way. There was considerable variation in students' experience of firm teaching, with some commenting on the lack of clinical experience or poor-quality tutorials, and others requesting more teaching with junior psychiatric trainees. Clinical teaching by its very nature is difficult to standardise as patients may not attend appointments and clinicians will have differing degrees of aptitude and

enthusiasm for teaching, but optimising the student experience is crucial, so novel ways of controlling quality must be sought.

The results of this survey will be used to inform changes to this particular teaching programme such as increasing the use of role-play teaching and emphasising the importance of structured firm teaching, with regular consultant tutorials as well as sessions with junior doctors. The findings could also inform adjustments to psychiatric teaching programmes at other institutions. More studies examining the specific components of undergraduate teaching programmes in psychiatry are required to establish which teaching methods students find most stimulating and which aspects need improvement. Shaping teaching programmes in this way may improve the overall undergraduate experience of psychiatry for students and perhaps even help recruitment into the specialty.

1 Simmons M, Wilkinson P. Lectures versus case discussions: randomised trial of undergraduate psychiatry teaching. *Psychiatrist* 2012; **36**: 146–50.

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The psychiatry experience from a medical student perspective

I am a third-year medical student in the last week of psychiatry rotation. Although many positives emerged from this experience of psychiatry, it is clearly useful to identify areas of weakness, as a good undergraduate experience is crucial to encouraging recruitment into the profession.

The first challenge facing my curriculum is from sharing timetable space with neurology in a 'brain-and-mind' rotation. It is perhaps an indictment of attitudes towards mental health that psychiatry is found in this position, something which is not required of my other third-year rotations. The very title 'brain and mind' is fatally misleading, insidiously suggesting that neurology is the 'brain' (i.e. the challenging, scientific area), whereas psychiatry is relegated to the 'mind' (and by association, the opposite) by medical school and students alike. I have observed the damage to the attitudes of students previously sanguine towards psychiatry originating from this false and simplified dichotomy.

With psychiatry being the Cinderella of the 'brain and mind' rotation, the contrast with the 'brain' of neurology is stark. Neurology lectures are delivered by a locally eminent neurologist, whereas a majority of the psychiatry lecture curriculum is delegated to nurses trained in medical education. I cannot be alone in suspecting that it would be considered unthinkable for the neurology component to be delivered by nurses, yet somehow this attitude is acceptable and pervasive in psychiatric undergraduate education. Part of a wider stigma, perhaps? That, of course, is not a criticism of the teaching delivered by the psychiatric nurses (and the multidisciplinarian approach is vital in psychiatry), but if attitudes (and therefore recruitment) are to improve among medical students, then it is essential that psychiatrists lead the taught curriculum. Not only would this potentially raise standards, but also provide students with psychiatric role models. Most can recall doctors or professors from their undergraduate years who were near idolised by students. To create this culture in psychiatry would give students considering a career in psychiatry a template of how they can progress. At present, however, psychiatrists are seldom found on the ward, or delivering lectures (a common issue raised by other schools). There is great difficulty even finding psychiatrists to facilitate the psychiatry problem-based learning. The blame for these problems is not confined to one organisation and progress is being made.

Nevertheless, I have enjoyed my psychiatry rotation and have been steeled towards the specialty as a career. It is encouraging to see a more evangelical approach to recruitment being propagated by the Royal College of Psychiatrists, and I look forward to the debate continuing.

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Driving in a crisis

We wholeheartedly commend Dr Sheridan on his recent article on fitness to drive[1] and thank him for highlighting such an important issue.

All drugs acting on the central nervous system can potentially impair alertness, concentration and driving performance. This is particularly so at initiation of treatment, soon after and when dosage is being increased. Driving must cease if adversely affected. Doctors have a duty of care to advise their patients of the potential dangers of adverse effects from medications and interactions with other substances, especially alcohol. The Driver and Vehicle Licensing Agency (DVLA) has published a list of psychiatric conditions and the requirements for notification. Its directives make clear distinction between group 1 drivers (of cars and motorcycles) and group 2 drivers (of lorries and buses). To regain the licence, the DVLA must be satisfied that an improvement in the mental state has been achieved and a period of stability has been fulfilled, which varies for every condition and between groups 1 and 2.[2] Crisis resolution teams deal on a daily basis with most of the psychiatric conditions which should be declared to DVLA, such as severe anxiety states or depressive illness, acute psychotic disorders of any type, hypomania/mania, chronic schizophrenia, personality disorders, and substance misuse. In addition, driving can be used as a means of suicide or as a means to harm others, which emphasises the need of a thorough assessment, accurate documentation and regular review. There are a number of incidences such as the tragic event of a mental health service user who lost control behind the wheel killing herself and two members of the public.[3]

I believe the assessment of fitness to drive should be incorporated in day-to-day risk assessment and clearly documented at each contact with crisis team service users. This is core business of every professional who comes in touch with patients. Patients deserve to be advised with regard to DVLA regulations, and indeed should stop driving if deemed unsafe and advised to contact the DVLA accordingly. The General Medical Council advises clinicians to tell patients with conditions which are likely to impair their ability to drive to inform the DVLA. If, however, the clinician does not assess and monitor the particular risk, they would be failing in their statutory duty, irrespective of their need to break confidentiality or not.[4]