should endeavour to provide job descriptions which contain clearly written and comprehensively detailed information. Employers may also wish to reflect on the detailed provision of resources associated with the post relative to the recommendations of the Royal College of Psychiatrists, and the influence that this may have on potential applicants. The Royal College of Psychiatrists through the network of regional advisors may possibly develop a broader role in such issues as a means of monitoring and sustaining quality standards in the appointment of appropriately trained doctors to adequately resourced consultant posts.

References

BARBER, S. G. (1992) Can selection of medical staff be improved? *British Journal of Clinical Practice*, **46**, 123–126.

BREARLEY, S. (1992) Specialist medical training and Europe. *British Medical Journal*, **305**, 661–662

DEPARTMENT OF HEALTH (1993) *Hospital doctors: training for the future. The report of the working group on specialist medical training*. London: DoH.

HUNTER, S. & MCLAREN, P. (1993) Specialist medical training and the Calman report. *British Medical Journal*, **306**, 1281–1282.

STORER, D. (1993) An educational model for medical appointments. *Medical Education*, **27**, 83–85.

WATTIS, J., NEAL, D. & PHILPOTT, R. (1987) Guidelines for regional advisers on consultant posts in the psychiatry of old age. *Psychiatric Bulletin*, **11**, 240–242.

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EDUCATION

The administration of general professional training schemes in psychiatry: a three year review

J. L. Herzberg and J. P. Watson

We have previously reported on the formation of a large regional registrar scheme covering 11 health districts in the South Thames region (Herzberg & Watson, 1991) and highlighted educational principles which we considered important for registrar training. The purpose of the present paper is to review those principles in the light of experience to date in running senior house officer (SHO) and registrar training schemes.

The educational needs of trainees are at all times of paramount importance

There is little doubt that the profile of in-patient services in inner cities has changed dramatically over the last ten years. There are fewer beds and the admission threshold is higher, length of stay shorter, and turnover greater. Patients are frequently behaviourally disturbed and present continuing management problems. The milieu may be overshadowed by matters pertaining to the management and prevention of disturbed and violent behaviour and may be understandably aversive for new trainees. The opportunities for relatively leisurely clerking, supervised formulation and informed discussion about patients, which were among the reasons for starting psychiatry with ward-based work, are relatively few. The College may need to reconsider these issues in conjunction with its guidance that in-patient general psychiatry

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experience is a requirement for the training leading to Part I examination. We think that consideration should be given to placing new SHOs only with out-patients or in less disturbed general psychiatry settings such as day hospitals which may deal with a wide range of neurotic and psychotic disorders and provide an environment in which trainees can maintain medium to long term contact with patients.

At the same time as the nature of in-patient services have changed within inner city areas, there has been a burgeoning of community based services, often based around community mental health teams. Trainee experience with community mental health teams including home visits for assessment or treatment, may be very valuable provided that close supervision is available; but the resource implications of adequate supervision are considerable and difficult to meet. The implications of training psychiatrists in multiprofessional settings may also be hard to meet, since non-medical colleagues may with reason consider themselves not under any obligation to train doctors unless their own personal terms and conditions of work specify this.

An organisational structure is required which allows proper participation of trainers and trainees in all affiliated districts

The regional health authority (RHA) remains technically the employer of registrars and is responsible for manpower matters, including the requirements of *Achieving a Balance* and of JPAC.

Since 1993 an increasing proportion of trainee administration has become the responsibility of the regional postgraduate deans. In SE Thames we are hopeful that this move of responsibility will allow the re-establishment of an efficient scheme administration. We regard it as essential that expenses which should be shared equitably between units participating in the scheme, are so shared. To do this requires a dedicated staff person, liaising appropriately with the postgraduate dean, United Medical and Dental Schools (UMDS), the RHA, and the units involved in the scheme. It would seem difficult to think of a simpler method of funding regional scheme support than by adding a suitable amount to the unit costs of trainee employment, but to date this per capita method of funding training has not been generally agreed.

A previous paper on this topic described the hope that education would be enhanced by central funding of study leave, maternity leave, removal expenses, travelling costs and any other unexpected major expenses. The plan was that these could be forward funded by region, cross-charged to a group of districts (units) in which the trainee had worked so that individual districts would not be overly penalised for the costs associated with long periods of sickness/maternity leave, when a trainee might have only 'happened to' have worked in a particular district for (say) six months. However, sensible arrangements for cross-charging disappeared with the decline of the regional health authority's administration. There is no doubt that it is now difficult for trainees to negotiate with individual districts and often assistance has to be sought from the local psychiatric tutor in negotiations with management across the region.

The scheme must have a plan for rotation which is practical and fair as well as educationally sound

When the scheme was set up it was decided that trainees should spend approximately half of their training working in centres outside London and half of their training within four largely inner London districts. This template has worked well. A greater variety of experience is available, in areas ranging from the extremely deprived to the ostensibly prosperous. The number of opportunities for training in child psychiatry, and in forensic psychiatry, have risen significantly. Psychotherapy training opportunities have extended and we are hopeful that the scheme will be able to meet the requirements of the new College guidelines for psychotherapy training for general trainees (Grant *et al*, 1993). We think it likely that the future in this area will lie with practitioners of brief, cognitive-behavioural, and group therapies, and that much useful training as well as service provision and evaluation will be made by general psychiatrist-therapists and non-medical psychotherapists. The SE Thames region has relatively few specialised medical psychotherapy consultants, and we are inclined to think that the number is unlikely to increase unless specialist psychotherapists

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make a stronger case for their value in NHS service provision than they have sometimes done.

Ideally the administration of a scheme should be done by a senior clinician whose time is funded

Practice has shown that the administration of a large regional scheme makes significant inroads into the time of the scheme organiser. The time varies from week to week across a year but two sessions per week should serve as an approximate guide. This does *not* include local tutorial duties and there is a second psychiatric tutor at the scheme organiser's hospital, who deals with the day to day administration of the local educational programme. The organiser visits trainees, tutors, and training sites, throughout the region at the midpoint of each post. Interviews with trainees at these times are used to ascertain educational needs and to make links between trainees and significant others in the university centre for encouragement of research, specialist career advice etc.

In addition, discussion between organiser and local tutor about problematic posts, and subsequent correspondence on behalf of the scheme, may facilitate beneficial change in the trainee timetable or job content. Meetings with UMDS scheme trainees working outside London takes four full days of scheme organiser time during each six month rotation period. Trainees placed within London are seen by local psychiatric tutors who liaise closely with the scheme organiser.

The way forward

We are currently uncertain of the Calman proposals for continuum training on the pattern of psychiatric training for senior house officers, registrars, and senior registrars. The registrar scheme committee is now accountable to the regional higher psychiatric training committee, of which the scheme organiser is a member.

There is continuing concern about arrangements for funding postgraduate medical education. In some units, trainee study leave is approved by the local psychiatric tutor and funded from the budget held by the 'clinical tutor' responsible for the local Post-Graduate Medical Centre. Sometimes, this mechanism works well. However, this seems to us inappropriate on educational grounds and it would seem essential that the psychiatric tutor should hold the psychiatric educational budget for the local unit. This would seem increasingly important as mental health units disaggregate into separate trusts, leaving 'clinical tutors' in completely separate administrative units.

We believe that the psychiatric tutor is in the right position and has the necessary expertise to agree an educational plan suitable for an individual trainee. It may be timely for each unit to appoint a local 'Director of Postgraduate Psychiatric Education' (DPPE) who would be responsible for the budget from the Postgraduate Dean and for signing on behalf of the unit the educational contract which the Regional Dean will henceforth require with all units taking trainees at any level. The DPPE might be well placed also to play a part in unit continuing medical education programmes which are likely to become mandatory.

Finally, we note that the health of a scheme throughout a region requires the continuing goodwill and commitment of all the participating units and tutors, and of those involved in the local university department.

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References

GRANT, S., HOLMES, J., & WATSON, J. (1993) Guidelines for psychotherapy training as part of general professional psychiatric training. *Psychiatric Bulletin*, **17**, 695–698

HERZBERG, J. L. & WATSON, J. P. (1991) Achieving a balance: establishing a new regional scheme for psychiatric registrars in South East Thames. *Psychiatric Bulletin*, **15**, 552–554

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