trainees involved, but it also indicates the degree of dispersal of psychiatric facilities into the community. It is not surprising that the number of hospitals and units correlates positively with the number of mandatory requirements.

Of the 49 schemes, 48 were approved and one was not.

It is of interest to know if the interval until the next visit is being used as a form of quality control. Correlation between the interval until the next visit and the number of mandatory requirements divided by the number of hospitals and units would suggest that this is in fact taking place. However, many other factors are also involved, including imminent changes in the training scheme such as linking up with other schemes, changes in personnel such as the appointment of key new consultants, and changes in buildings such as the planned closure of an old mental hospital. Sometimes the organisers of the training scheme themselves may request a rapid return visit. New schemes or schemes that have previously been unapproved and now are requesting further approval will always require and receive a rapid return visit.

Mandatory requirements are mostly directed at the consultant psychiatrist including the tutor. The two key elements in training remain consultant supervision and an emphasis on practical clinical training. Clinical supervision by the consultant requires individual contact and teaching, discussion of in- and out-patients, ensuring a satisfactory level of case note recording and other ward activities. Practical training in the hospital or unit requires an induction course for new trainees, good training in and supervision of ECT and provision of training in interviewing, with case conferences and journal meetings.

The Approval mechanism was initially established by Professor Rawnsley, the first Dean of the College. Over the subsequent years it has made an important contribution to improving training standards in psychiatry, raising clinical standards in hospitals and hence improving the care of patients.

Acknowledgement

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Clinical tutors' survey 1988

Registrars and senior house officers in psychiatry

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The Government's proposals in the White Paper have given rise to exceptional controversy and concern not only among professional groups working in the NHS but also among the general public. It is therefore not surprising that the medical profession has somewhat lost sight of the significance of the radical proposals in the report issued in October 1987. The report *Hospital Medical Staff: Achieving*

a Balance 'Plan for Action' (1988) was issued on behalf of the UK Health Departments, the Joint Consultants Committee and the Chairmen of the Regional Health Authorities. The report, after a careful review of the alternatives, formulated proposals for an integrated package of measures to achieve gradual reform of hospital staffing structures in the interests of patients and doctors alike. The results of deliberations identified three principal areas:

(1) an increase in the number of consultants to provide leadership and career opportunities
(2) sensible planning of the number of doctors in career training grades, taking account of career prospects
(3) maintenance of necessary levels of support for consultants particularly in the acute specialities.

In this context it is worth remembering the changes in the immigration rules which came into effect from 1 April 1985 affecting entry of overseas doctors to the UK. Prior to 1 April 1985 overseas doctors were not subject to the normal work permit arrangements but were freely admitted to the United Kingdom and given permission to stay to take up professional appointments if they satisfied the relevant registration requirements of the GMC. The change in the rules means that doctors seeking entry into the UK for the purposes of post-graduate training in hospitals may have permit-free training status for a total aggregate period of four years and will be expected to leave the UK on completion of the training period. The broad implications of these changes in the rules are that there are no restrictions on the employment of those overseas doctors who were in the UK before 1 April 1985. Those entering subsequently and undergoing post-graduate training have no employment restrictions for a maximum of four years but locum appointments will largely have to be filled from among doctors already in the UK who have no restrictions on their employment.

The document *Plan for Action* discusses consultant expansion and the appropriate changes required to meet this expansion in the number of senior registrar posts in the specialty. This principle, in particular the need to relate the number of UK graduates in training to future consultant opportunities, applies with equal force to the registrar grade, since it is generally difficult to change direction after training for two or three years in a registrar post. The doctors who enter the grade are therefore, in fact, committing themselves to a career choice and they should, in return, have a reasonable expectation of gaining consultant status if they complete higher training satisfactorily. Application of this principle will mean that in many specialties there will be a significant reduction in the number of registrar posts available to UK graduates (overseas graduates who entered the UK prior to 1 April 1985 are treated as UK graduates for this purpose). The DHSS, on advice from JPAC, will allocate to each Region quotas of UK qualified registrars – to be called "career registrars" – in each specialty. Those who entered the UK after 1 April 1985 and who qualified overseas will be known as "visiting registrars". To help improve the planning of these changes in registrar posts and development of rotational training schemes, control of all registrar posts will be transferred from District to Regional Health Authorities.

The document recognises that the great majority of doctors seeking a hospital career may look forward to the possibility of a consultant post at the end of training, although there will be a smaller number who cannot – or do not wish to – complete higher training. To accommodate such a group a new grade called "staff grade" has been introduced, and entry to such a grade will be by open competition. These are the doctors who have been described as "stuck doctors" who, for whatever reason, seem unable to make further progress in their present careers. It is hoped that District and Regional Health Authorities will identify them and offer counselling and the possibility of retraining and/or an extension of their contract – in very exceptional circumstances granting a five year rolling contract in the present post.

At the present time, neither employers nor the College collect the data required in a systematic manner to identify the doctors failing to progress in their career aspirations, whether they are 'stuck' and if so what possible help can be offered to them. With the encouragement of the Education Committee and the Clinical Tutors' Committee of the College it was decided to prepare and finalise a simple questionnaire to survey clinical tutors to identify psychiatrists in registrar and SHO grades in training schemes in the UK. Although a direct and detailed questionnaire sent to each doctor in the grade would have been more informative and desirable, such a study would have been far too complicated and expensive. It was therefore decided to submit the questionnaire to tutors and the organisers of training schemes recognising the possible short-comings of such a method.

The study

In May 1988 a postal questionnaire was sent to all general tutors, specialty tutors and course organisers known to the College to carry out a census of doctors in the training grades of registrar and senior house officer. The information requested was: name and/or initials, grade, year of birth, sex, country of basic medical qualification, registration status, post-graduate qualification obtained in the UK (if any), year of commencing psychiatric training in the UK and year of commencing work in the NHS. One reminder was sent to non-respondents and, by the

end of 1988, 65% had returned the completed questionnaires. The respondents were, however, able to provide information for 75% of the registrars currently employed. Several tutors wrote expressing their inability to provide the information on the grounds of objection from trainees and/or because of their personal belief that giving this information might breach confidentiality even though complete assurance was given that neither the hospitals nor the doctors concerned would be identified individually.

Findings

The analysis of the data regarding senior house officers did not reveal findings of any significance and therefore this report concentrates on those in registrar grades. Of the total number of registrars in the sample 397 (70%) were UK graduates and 172 (30%) were overseas graduates. These figures show a reversal of the situation which existed in 1978 when 66% of registrar posts were occupied by overseas doctors. It is clear therefore that twice the percentage of UK graduates are training in psychiatry compared to ten years ago. Of the UK graduates 58% are males and 42% are females while among the overseas graduates 72% are males and 28% are females.

Interestingly, fewer overseas doctors are working in Scottish and South West divisions of the College compared to the Midlands or East Anglia. The age distribution of registrars in training grade confirms known trends. Of UK graduates, 89% are under the age of 35 years compared with 29% of overseas graduates. Only 2% of UK graduates are over the age of 40 years whereas 35% of the overseas graduates are older than 40 years.

Overseas doctors arriving for training in the UK have always been known to be much older than the indigenous graduates, as many have spent some years working in their countries of origin prior to deciding to emigrate. Nevertheless those over the age of 40 who remain in the grade (35%) are likely to encounter difficulties in advancing further even though it is illegal to discriminate on the grounds of age. A similar problem may be encountered by a small number of UK graduates (2%).

The decision was made to divide experience in psychiatry into three groups: those who have worked in psychiatry for less than five years, those who have spent between five and eight years and finally those who have been working for over eight years (Table I). Out of a total of 369, 209 UK graduates (57%) had obtained either part I or part II of the Membership examination as opposed to 42 (26%) of the overseas graduates in less than five years. The relatively poorer performance of overseas graduates in the College examination compared with those of UK and Eire graduates is similar to the situation reported by Cawley (1986). Thirty-three (9%) of UK graduates appear to have passed part I and/or part II of the Membership compared to 40 (25%) of the overseas graduates between five and eight years after having entered psychiatry. These data yet again confirm findings reported by Cawley and others that overseas graduates take longer to obtain post-graduate qualifications and therefore have higher pass rates in the later years of their training. A small number (1%) of UK graduates appear to have taken over eight years compared to 10% of overseas graduates to pass Membership examinations. The figures of overseas doctors were adjusted to enable comparison.

TABLE I
Clinical Tutors Survey 1988

Experience in psychiatry	*UK graduates*				*Overseas graduates*			
Years	*No post-graduate qualifications*	*Part I MRCPsych*	*Part II MRCPsych*	*Total*	*No post-graduate qualifications*	*Part I MRCPsych*	*Part II MRCPsych*	*Total*
	n	n	n	n				
0–5 years	113	154	55	322	48 (109)	33 (75)	9 (20)	90 (204)
5–8 years	8	15	18	41	13 (29)	20 (45)	20 (45)	53 (119)
8 years +	2	2	2	6	4 (9)	8 (18)	8 (18)	20 (45)
				369				163 (368)

Numbers in brackets are adjusted figures of overseas doctors.
Details on 37 doctors were insufficient and therefore not included.

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Comments

(a) The point prevalence survey of registrars in psychiatry shows that 9% of UK graduates have been in training grades over five years compared to 25% of overseas graduates. Both these groups require careful appraisal of their examination performance as well as any personal difficulties they may be encountering. A smaller but much more worrying group are the ones who have been in psychiatry over eight years (UK graduates 1% and overseas graduates 10%). This particular group should be considered 'stuck' and may merit special attention.

(b) With examinations in any country, indigenous candidates do better as a group (Cawley, 1986) compared to those coming from other countries. Success in the Membership examination is a minimum requirement for advancement to a senior registrar grade. Overseas trainees, however, continue to pass Membership even after eight years of being in psychiatry and a proportion fail to achieve this. A training in a specialty such as psychiatry for such a long period is likely to make it more difficult for these doctors to move to other branches of medicine as was envisaged in the document *Plan for Action*. This group therefore will require either an extension of their contracts or guidance regarding taking up staff grade posts.

(c) It is anticipated that in the near future registrar rotations will be regionally managed. This will provide opportunities for Regional Medical Officers, Post-graduate Deans and, above all, academic departments and course organisers to begin to create a data bank which will lend itself to careful analysis of the registrars in training in the Region as well as those who seek jobs having completed registrar training in other regions. Such a procedure will help to identify the trainees most in need of counselling and career advice.

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Conference report

Seminar on overseas doctors in the United Kingdom

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The training of overseas doctors mainly from the 'third world' is a subject which has featured in various dialogues on postgraduate psychiatric education in the United Kingdom in recent times. The issue was again brought into focus on 18 November 1989 at the School of Postgraduate Medicine and Biological Sciences, University of Keele, Stoke-on-Trent at a seminar which examined pertinent key areas. Five topics were covered by speakers familiar with 'third world' training needs.

In an opening paper, Dr Digby Tantam (Manchester) informed his audience about postgraduate training opportunities for foreign doctors, borrowing heavily from the well-organised Manchester training scheme he co-ordinates. Dr John L. Cox, Professor of Psychiatry at Keele, gave a succinct update on the special psychological difficulties confronting foreign doctors in 'alien' Britain. Dr Bipin Upadhyay (Stoke-on-Trent) a trainee of Afro-Asian background on 'A trainee's view' offered peers some useful practical advice. Dr O. O. Famuyiwa (Lagos, Nigeria) called for positive changes in attitude towards the curriculum to make the UK training structure more relevant to developing countries, and in a thought-provoking address, Dr Neil Holden (Nottingham) dwelt on the significance and feasible modes of international collaboration.

The enthusiastic participation of delegates completely annulled the effect of small audience size and the pooled information obtainable from the seminar should be a rich fountain of guidelines for those with an interest in and commitment to overseas doctors in the United Kingdom and elsewhere.