The sheer quality of experience spent in session with in-patients is immensely valuable. There are no SHOs at the hospital and registrars are very much adopted by the senior registrar group. We joined them for supervision of group and out-patient work (including brief focal psychotherapy and marital therapy) and academic seminars, journal clubs and case presentations. Supervision of the nurse–therapist relationship is also provided. Overall, a rich academic and clinical milieu is created by a relatively large number of psychotherapists often with rather different trainings and perspectives.

In looking at the differences in our experiences of the two jobs, we found that the day-to-day nature of the work of the different units was often so different that we found ourselves unable fully to understand and support one another. This dynamic is important when considering the isolation of trainees that could be experienced in such an attachment, especially when geographically separated from the bulk of peers in other training posts, when trainees are sometimes in an unfamiliar culture and when other peer groups in the hospital are significantly larger than theirs. The effect of constant changes due to registrar turn-over on the smooth running of the institution has also to be considered. Juniors on training rotation schemes are generally used to having to adapt rapidly to different working environments. However, the beginning and end of a short attachment can be associated with much intra-psychic and institutional turmoil which leaves a relatively small amount of 'settled time' in the middle, especially for two inexperienced psychotherapists. Furthermore, nine months is not long enough to see a full in-patient treatment through from beginning to end.

In summary, very positive aspects were the variety, volume and intensity of the clinical experience and the clear demonstration of institutional dynamics. Relatively negative aspects were the potential for isolation and the sorts of conflicting pressures we were subject to, the latter perhaps being inescapable. Since moving on to new jobs in general psychiatry we are both aware of some difficulty in incorporating our experience into our new areas of work where aims of treatment can be considered to be very different.

In conclusion we thoroughly recommend this experience and hope that the future will see similar opportunities for trainees being more readily available.

At the time of writing, we are sad to hear that the Cassel is under threat of closure, and we fully endorse the viewpoint of a recent article on the Henderson Hospital in the *Psychiatric Bulletin* which stresses the importance of specialist treatment centres for training as well as service provision.

(*Editorial note*: The District Health Authority's closure proposal put forward earlier this year has been withdrawn following agreement on plans to raise funds and make arrangements for the hospital to opt out in April 1991.)

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Psychiatric Bulletin (1990), **14**, 543–548

Training matters

A model of training for consultancy in psychiatry

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In the medical profession a consultant is a doctor who has attained the capacity for totally independent practice, otherwise known as clinical freedom. Consultants differ from other doctors in the important respect that they have full clinical responsibility (BMA, 1984). The work of the consultant may be audited by his peers, with his full participation, but may not be supervised by one (DoH, 1989a).

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Thus, whereas the consultant is accountable, administratively, to his employers, in the clinical area, he is not accountable to any other doctors or managers: he is accountable to the General Medical Council for his professional conduct, and, with respect to the diagnosis and treatment of illness, to the patients directly, the patients' relatives, and the law of the land.

The law relating to the appointment of consultants

The Medical Act 1983 (House of Commons, 1983) establishes who may be registered as a medical practitioner, and sets out the types of registration that may be granted to medical practitioners.

The National Health Service (Appointment of Consultants) Regulations 1982 (House of Commons, 1982) covers the conditions surrounding the appointment of consultants. This legislation does not specify the qualifications necessary in order to be appointed a consultant, beyond stressing that the Advisory Appointments Committee must be satisfied that the candidate is professionally suitable for the post. The current NHS Review White Paper places special emphasis on the question of managerial suitability, "... in view of the crucial role of Consultants in committing expenditure and influencing the pattern of health care provided, ..." (DoH, 1989b).

The need for something beyond full registration

It has long been clear that being fully registered is not a sufficient basis for undertaking the responsibilities of consultancy. Hence the various Royal Colleges have established training programmes and qualifying examinations to enable doctors to achieve the level of knowledge and experience necessary for consultancy.

The Royal College of Psychiatrists' requirements

The Royal College of Psychiatrists has established two levels of training on the way to consultancy. The pre-Membership or junior training covers the initial three-year rotational training scheme leading to Membership of the Royal College of Psychiatrists (MRCPsych). The post-Membership or senior training covers the years of senior registrar (SR) training.

On completing senior training, the doctor is then considered qualified to seek appointment to a substantive consultant post (JCHPT, 1985).

At present therefore, doctors wishing to become consultants in psychiatry go through a series of screening procedures, in the course of which some people are unfortunately 'weeded out' because their aspirations are not matched by their ability, while others fail to achieve their full training potential because, despite the noble intentions of its designers, the 'system' has not yet achieved the capacity to function fully as an equal opportunities organisation.

Candidates are first screened when they apply to get onto a rotational training scheme for the MRCPsych. The second level of screening is the Part I MRCPsych examination. The third level is the Part II MRCPsych.

The bottle-neck

If all the doctors working in the field of psychiatry in this country were to be assembled on a large field in accordance with the posts they occupy, they would form a figure roughly the shape of an hour-glass, consultants occupying the top of the vessel, SRs the neck, and the junior trainees (SHOs and registrars) the bottom.

That bottle-neck at the SR level results because the fourth level of screening is introduced directly after doctors have become Members of the Royal College of Psychiatrists. What this means, in practice, is that many doctors who have progressed through their training to the MRCPsych suddenly find that they cannot easily continue on the way to consultancy. This is a situation that, fortunately, can easily be rectified.

The value of membership of the Royal College of Psychiatrists

What then is the value of the MRCPsych qualification? It would appear that it simply indicates one's potential to undertake further training on the way to consultancy. It does not indicate that one is considered yet capable of independent medical practice. Should not the MRCPsych qualification have a greater value than this? I think it should be worth a lot more.

Realising the training potential

It is therefore essential to re-design the system of training so that there is the assurance that every doctor who embarks on training in psychiatry has an equal opportunity to achieve Membership of the Royal College of Psychiatrists; and that those who do attain the MRCPsych are fully capable of independent clinical practice, and hence able immediately to seek consultant posts in general psychiatry, unless they opt for training in another specialty.

The principle being proposed here is that Membership of the Royal College of Psychiatrists should be seen, not just as the indication that one is capable of

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further training for consultancy, but as a sufficient basis for appointment as a consultant in general psychiatry.

For this to be so, the Examination for Membership of the Royal College of Psychiatrists would need to be in three parts – Part I, Part II and Final (Part III) – instead of two.

The recommended model of training

In keeping with the spirit as well as the letter of *Hospital Medical Staffing: Achieving a Balance* (DHSS, 1984 and 1986), a doctor who embarks upon the pre-membership training should automatically be considered a candidate for consultancy. The system will not work against the candidate at any stage; if he does not make it to consultancy, it will only be because he failed the main screening examinations.

This means that a bottle-neck should not exist at the SR level. To bring this about, the SHO/registrar and SR training should be merged in every rotational training scheme and offered as SHO/registrar/SR training rotations, so that progress from SHO to SR would be on the basis of promotion rather than competition.

Training at the SHO level should span a period of one year, which should be devoted to gathering knowledge and experience in general psychiatry and in the basic sciences related to psychiatry. At the end of this one-year period, the doctor would be eligible to attempt the Part I MRCPsych.

Promotion to registrar in psychiatry should be conditional upon success in the Part I examination. In the three years as registrar, the trainee would spend six months in each of the following specialties: psychotherapy, psychogeriatrics, forensic psychiatry, child and adolescent psychiatry, mental handicap and substance misuse. This phase of training would qualify the doctor to sit the Part II MRCPsych.

Success in the Part II MRCPsych would lead to the promotion of the registrar to senior registrar. The two years of SR training should be spent in consolidating knowledge and experience in general psychiatry, administration, teaching and research. At the end of this two-year period, the senior trainee would become eligible to attempt the Final (Part III) MRCPsych.

By requiring doctors to sit the Final (Part III) MRCPsych after a minimum period of six years' training instead of three, the College would ensure that doctors are considerably more experienced when they become Members of the Royal College of Psychiatrists than is the case today. The Part III examination could also include the submission of either a research thesis, or a book of case records, detailing cases actually managed by the doctor concerned, and critically analysed by him.

Success in the Part III examination would lead to the award of the Certificate of Membership of the Royal College of Psychiatrists, as well as a Certificate of Accreditation as a Specialist in General Psychiatry. The doctor would now be qualified to seek appointment as a consultant general psychiatrist on either a *locum tenens* or a substantive basis.

If the doctor wished to pursue further training in another specialty, he could now be promoted to the new post of junior consultant psychiatrist with special responsibility (JCPSR), within the same training scheme. Training at JCPSR level should last two years, both years being devoted to the doctor's chosen specialty. During these two years, he would be as much a consultant as any more senior colleague, taking on full clinical responsibility for a small portion of the catchment area of his clinical tutor, participating in research, and teaching.

In the usual manner of things, there will always be posts that will need to be filled on a *locum tenens* basis, in the short or long term. These posts usually arise from retirement or resignation vacancies, prolonged illness of the post-holder, maternity leave, sabbatical leave or some unforeseen circumstance. Sometimes these are newly created posts waiting for applicants.

The sustenance of the service in these situations requires that some doctors with the right level of training should be willing to do temporary work in the long term, and is essential for the continuity of the work of the relevant Health Authorities' Mental Health Units. It can safely be said that without the contribution of locum consultant psychiatrists, many Health Authorities would be unable to provide significant elements of their service. This is why it is such a strange anomaly that a doctor who has sustained a service for, say, a couple of years on a *locum tenens* basis, is then told that he is unqualified to do the same work on a substantive basis! This is easily rectified, as can be seen by the suggestions offered in this model of training for consultancy.

It is hereby proposed that *locum tenens* consultant work, because of the importance of its contribution to the Health Service, should be given greater recognition. Some doctors may choose, on becoming Members of the Royal College of Psychiatrists after six years of training, to work as locum consultant general psychiatrists, to cover vacancies arising in various Health Authorities' Mental Health Units. Some doctors find it more interesting to work as locum consultants, moving on from a job before they become too deeply entrenched in the situation. Others would like to do locum work until they are able to find a substantive post. Either way, their work should be seen as of equal value to that of the substantive appointee they are holding place for.

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The special responsibility accreditation examination

By moving the goal-post such that the Final (Part III) MRCPsych is taken after six years of training, the value of the qualification is considerably enhanced, insofar as it represents a sufficient qualification for appointment to consultancy.

Those who opt for specialist training as junior consultant psychiatrists, or as locum consultant psychiatrists, with special responsibility, would have to sit an examination at the end of the two-year training period, to confirm their status as specialists in their chosen areas additional to the training they have had in general psychiatry.

I propose that this be called the Special Responsibility Accreditation Examination. The qualification achieved by success in this examination would be rewarded by the award of a Certificate of Accreditation as a Specialist in Forensic Psychiatry, Substance Misuse, Psychogeriatrics, Child & Adolescent Psychiatry, Psychotherapy, Mental Handicap or (some day) Liaison Psychiatry, and the eligibility to seek a substantive appointment as a consultant psychiatrist with special responsibility.

The Special Responsibility Accreditation Examination would be a test of clinical acumen, administrative ability, teaching skills, familiarity with the conduct of research and the evaluation of research papers, and, of course, a special degree of knowledge in the field of specialty. It could be an entirely oral examination.

Conclusion

This model of training for consultancy in psychiatry offers a number of principles:

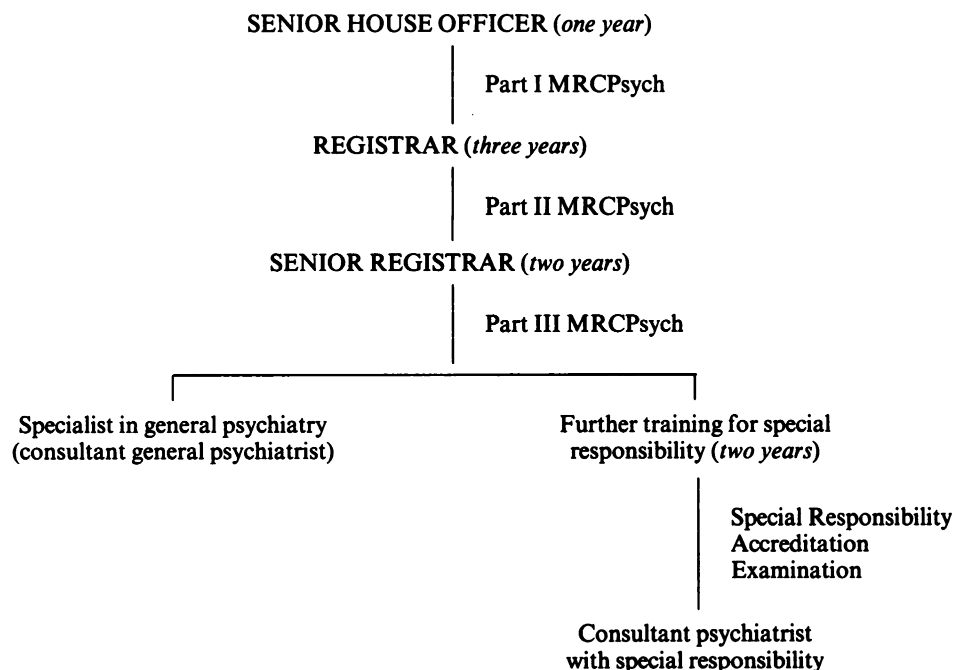
First, every doctor who embarks on training in psychiatry should be considered a potential candidate for consultancy, and given every possible opportunity to fulfil his training potential.

Second, the training of SHOs, registrars and SRs should be merged, offered as an integrated SHO/Registrar/SR package in every rotational training scheme.

Third, once accepted for training in psychiatry, the doctor should not face any further job interviews until he is ready to seek a consultant post. Progress from SHO to registrar to SR should be based on promotion not competition as the candidate succeeds at the first two parts of the MRCPsych examination. This would eliminate the 'bottle-neck' at our present SR level.

Fourth, the training for Membership of the Royal College of Psychiatrists should be spread over six years, instead of three, the examination itself being in

Summary Chart



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three parts, instead of two. Success in the Final (Part III) MRCPsych examination would be coupled with accreditation as a specialist in general psychiatry.

Finally, on achieving Membership of the Royal College of Psychiatrists, the doctor would become eligible to seek appointment as a substantive or *locum tenens* consultant general psychiatrist. Those who desired further training in another specialty could branch off at this point and undertake this as junior consultant psychiatrists, or locum consultant psychiatrists, with special responsibility. The difference would be that junior consultant psychiatrists have only a limited catchment area responsibility, whereas locum consultant psychiatrists would undertake the full responsibility of the substantive post for which they are covering.

After two years of further training in the desired specialty, the Special Responsibility doctor would be able to sit the Special Responsibility Accreditation Examination. Success in this examination would enable him to seek substantive consultant posts with a special responsibility.

There is an additional advantage of this proposed model of training over the current system, insofar as SR training would lead to the Final (Part III) MRCPsych, which itself would be a gateway to at least four options. There can therefore be no such thing as 'time-expired' senior registrars.

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Dear Editors

Thank you for allowing me to see Dr Azuonye's interesting article on 'A Model of Training for Consultancy in Psychiatry'. A lot of the suggestions he makes have, of course, been debated extensively at the Examination Sub-Committee and the Court of Electors, and in the Education Committee of the College over several years.

Dr Azuonye is suggesting replacing our present Part I and Part II of the MRCPsych examination, which takes place over three years of training with a new MRCPsych examination with four separate stages (Parts I, II, III and special responsibility accreditation examination) over six years. Most of those concerned with postgraduate medical education in general and psychiatric education in particular consider that we have an excess rather than a deficiency of examinations. It is important, of course, that trainee psychiatrists have a required level of knowledge and at the moment we have found no better way of testing this than an examination. However, there are considerable disadvantages in concentrating trainees' minds entirely with passing examinations: it inhibits research creativity and would do so to a greater extent if examinations were extended over a longer period, and it prevents training and experience in important areas that cannot easily form part of an examination syllabus, for instance psychotherapy. The whole emphasis of senior registrar training is not to learn facts by rote for regurgitation under examination conditions but to train already relatively experienced psychiatrists in the art of being a psychiatrist, running a service, managing a multidisciplinary team, using the available resources, keeping up to date with developments in psychiatric knowledge and so forth. It is a completely different approach to learning and would be totally destroyed by introducing an examination at the end of it. This same debate is currently going on within the Royal College of Surgeons, who are also wondering about a Part III examination on completion of senior registrar training. There are serious misgivings being raised also in that College about this suggestion.

Dr Azuonye makes no mention of what many of us would regard as the most important contribution the College has made to training, that is the regular inspection and approval of training schemes in psychiatry. In my opinion, this makes a greater contribution to training and to standards than the introduction of yet more examinations, and making the criteria for approval more competitive would probably have a better effect also than increasing the number of examinations.

Dr Azuonye is proposing that there should be no interviews in psychiatry after appointment to senior house officer post until the doctor applies for a consultant post. The current position, of course, is that now Appointment Committees must be held between senior house officer and registrar post, and *Achieving a Balance* suggests that eventually the boundary between registrar and senior registrar posts will be removed. Automatic promotion is stultifying whereas a bottleneck with extremely difficult promotion is demoralising for the unsuccessful candidate and wasteful for the service. The answer for the current bottleneck between registrar and senior registrar grades is to create more senior registrar

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posts in psychiatry, which are urgently needed for consultant vacancies.

Dr Azuonye also discusses locum consultant positions in psychiatry. Ideally, every locum consultant should be eligible for a substantive consultant post, that is, the doctor concerned should have passed the MRCPsych examination and completed higher training in psychiatry. Unfortunately at the moment many Health Authorities are appointing as locum consultants in psychiatry people who have not completed the necessary requirements. The reason they are doing so is, of course, because we have an inadequate number of senior registrar posts and therefore an inadequate number of trained senior registrars for consultant vacancies. Once again the solution to this difficulty is the establishment of more senior registrar posts.

It is difficult to see how the suggestion of replacing interviews between training grades in psychiatry with examinations will achieve any real benefit. It would be highly disadvantageous to training to continue with examinations throughout a six year period. It would have a disastrous effect upon psychiatric research at a trainee level at a time when people are potentially very creative. It would also be highly disadvantageous for trainees in specialties such as child and adolescent psychiatry, who instead of being able to enter their chosen specialty after three years in psychiatry, would be prevented from so doing until completion of six years experience.

Finally, Dr Azuonye claims that his model would prevent "such a thing as time expired senior registrars". There are no time expired senior registrars at the moment. In fact the concern is that trainees move out of senior registrar into consultant post too quickly because of the shortage of trained senior registrars.

A. C. P. SIMS
Dean (July 1987–July 1990)

(see Correspondence, p. 565)

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Emergency and liaison psychiatry

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Background

The post of Emergency and Liaison Registrar in the Bloomsbury Rotation was created in 1988 to provide a psychiatric service at University College Hospital, London, in the Accident and Emergency (A&E) Department and to the A&E Ward for assessment of deliberate self harm (DSH) cases. It incorporated existing commitments of liaison to the UCH wards and provision of urgent psychiatric assessments. The service had previously been shared among a number of psychiatric staff. The registrar can thus be seen as a 'central pivot' within the District Psychiatric Services.

The Bloomsbury Health Authority provides health care in an inner city district. The resident population is approximately 135,000 and in the daytime is increased considerably by visitors and commuters. The composition of the resident population is diverse, multiracial, contains a wide spread of social classes and a large number of single person households. An important determinant of the district's composition is its high proportion of homeless persons. This is related to a number of factors; for example, there are three major railway stations within the district (daily passenger numbers exceed 150,000), and a large number of DSS bed & breakfast hotels.

Description

We saw 325 new cases over one year. These consisted of: A&E 101; DSH 99; general practitioner referrals 69; liaison cases 56.

The commonest reasons for referral from the A&E Department were: assessment of suicide risk 45.7%, bizarre behaviour 32.6%, recent relapse 15.2%. The A&E cases necessitated immediate assessment due

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