(c) *Working alone* No matter how carefully a case was set up, once I was in the room with the patient, I knew I was working on my own.

Acknowledgement

I should like to thank colleagues at the Tavistock Clinic without whose firm encouragement this account would not have been written.

Reference

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Comparison of 'on-call' experience in two different training schemes in psychiatry

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The natural grouping of training rotations in psychiatry into those based on a central University Teaching Hospital and those in a peripheral location invites comparison between the two groups. Training perspectives in two neighbouring schemes, one in each category, have been explored recently (McWilliam & Morris, 1988). It was noticed that, although styles differ, resulting clinical competence is comparable. An important part of clinical training is out-of-hours experience. For approval of a rotational scheme, experience of on-call duties and emergencies is necessary (Royal College of Psychiatrists, 1987). We were interested in comparing on-call duties in two different types of scheme, one in Sheffield, the other in Chichester.

The Sheffield rotation is based at a University Teaching Centre with the workload divided between a large mental hospital and a psychiatric unit based in a District General Hospital. The non-resident on-call commitment is one in seven and the duties are divided into three categories, admissions, general medical cover, and casualty. When on call 5 p.m. to 9 a.m. for admissions the junior doctor is generally the first point of contact for all admissions. Referrals cover all of Sheffield (catchment population involved is 450,000). The trainee actually covers the 24 hour period 9 a.m. to 9 a.m., but calls 9 a.m. to 5 p.m. occur only in exceptional circumstances when the usual ward doctor is not available. When on call for medical cover, the trainee is available for all psychiatric, medical and surgical problems for a total of 110 acute admission beds, 25 bedded academic unit, 296 long-stay, 60 rehabilitation, 249 ESMI, 53 acute elderly functional and 51 dementia assessment beds. When on call for casualty, the trainee covers all referrals from two large District General Hospitals, including all medical and surgical wards from these hospitals. The Sheffield scheme involves pre-Registration House Officers doing some first on-call duties for admissions and medical and general psychiatric calls but not for casualty. The trainee has back-up cover from a senior registrar (SR) and a consultant. The SR on call is designated the consultant's nominated deputy for the Mental Health Act.

Graylingwell Hospital, Chichester is a large mental hospital covering a mainly rural catchment area consisting of two Health Authorities, Chichester and Worthing, with total populations of 179,000 and 243,000 respectively. The on-call rota was one in seven for three months and one in five for four months. The trainee is resident and is the first point of contact for admission requests, and medical (including cardiac arrest) surgical and psychiatric in-patients' problems. On-call duties run from 9 a.m. to 9 a.m. For three months of the study both areas were covered involving 82 acute admissions, 184 long-stay, 30 rehabilitation, 144 psychogeriatric, 17 acute elderly functional, and 27 dementia assessment beds. Functionally ill patients over 65 from Worthing were not included nor were acute admissions under 65 from Worthing in the latter four months. Cover for Accident and Emergency or District General

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Hospital in-patients is not included, this being provided by the consultant on call. The trainee has back-up from the consultant and is designated as the nominated deputy for the purpose of the Mental Health Act.

The study

All calls received while 'on call' were logged in a diary consisting of a pro forma sheet for each day. Detailed against the time of each call were caller, reason for call and action taken. The period of study was from 1 January to 31 July 1988. This included four weeks leave for PD, yielding 28 on-call days, and six weeks leave for KR, yielding 26 days.

The total number of calls on the Chichester rotation was 371, with 280 of these out-of-hours. In Sheffield the total number was 73, with 70 out-of-hours. We focused primarily on the latter calls, those received from 5 p.m. to 9 a.m.

Of PD's on-call days the duty breakdown was as follows: admissions 16, casualty eight and medical cover four. On five out of the 28 days, PD was second on-call, and he received no calls on four of these days. Of the 23 days first on-call PD received calls on all but one day. All KR's duties were on a first on-call basis and he received calls on all of the 26 duty days. KR received a total of 280 calls, and PD 70 calls. Nineteen (7%) of KR's and 23 (33%) of PD's calls were for admissions. The breakdown of the sources and numbers either admitted or deferred are shown in Fig. 1. One hundred and thirty-seven (49%) of all calls in Chichester were for medical problems and in

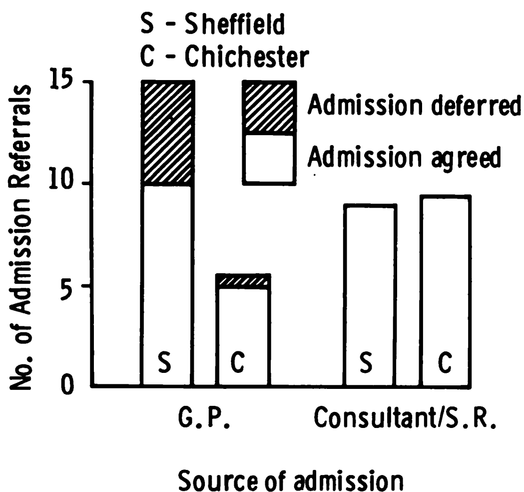

FIG. 1. Number of admission referrals by source, highlighting disposal, either admitted or deferred.

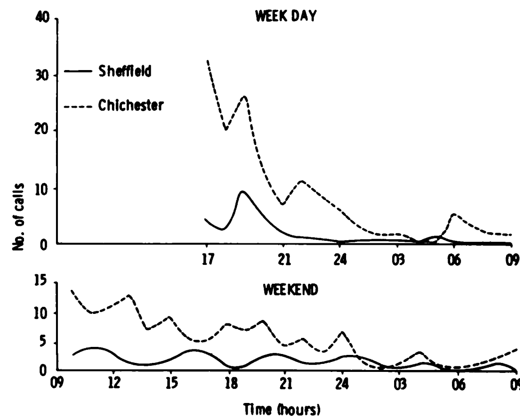

FIG. 2. Number of calls by time: for weekdays and weekends.

122 (89%) of these KR had to attend the patient. Only 59 (21%) of calls were for psychiatric problems and 33 (55%) of these required attendance. Four (6%) of the Sheffield calls were for medical problems and in only one did PD have to attend the patient. In Sheffield 20 (29%) calls were from acute admission wards informing the trainee of the arrival of admissions, compared with 22 (8%) of calls in Chichester.

While on casualty duty in Sheffield PD was asked to see and give a psychiatric opinion on 14 patients, eight on medical wards and six in casualty. Of these 14 referrals, four were admitted to a psychiatric ward, seven were discharged home, two deferred, and one advised to stay on medical grounds. In Chichester two of the 280 calls received by KR resulted in him personally applying Section 5(2) of the Mental Health Act 1983.

Variation in the timing of calls is compared in Fig. 2A and 2B, and it can be seen that the timing of calls follows a similar trend in both schemes. This holds for weekdays and weekends.

Comment

Methodological problems exist in the direct comparison of the two schemes. On the Sheffield scheme in-patient medical and psychiatric calls are under-represented due to the pattern of rota commitment during the study period. The seven month period of the study is relatively short and therefore can only give a 'flavour' of the on-call experience. There is also the bias introduced by variation in practice between the two trainees. However, this may have been reduced to some extent by the fact that both had

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worked together in a small team prior to joining the two schemes under comparison. Despite the above considerations we feel that general trends can be described.

The number of admission requests and subsequent admissions was roughly equal, 18 admissions in Sheffield and 15 in Chichester. When corrected for the catchment population admission rates remain similar, one admission per 100,000 total population per on-call day every 7.0 days in Sheffield and every 7.6 days in Chichester. The total number of calls in Chichester was four times that in Sheffield, 280 compared with 70. When corrected for populations covered the difference remains four-fold, with Chichester and Sheffield having 2.45 and 0.59 calls per day per 100,000 total population respectively.

Of the Chichester calls, 49% were for medical conditions which required the trainee's attendance in 89% of cases. This obviously represents a considerable amount of clinical time. The question it raises is of appropriate experience while on call. It is of course necessary for psychiatric trainees to maintain and develop their general medical skills while undergoing psychiatric training. Others (Rigby & Oswald, 1987) have highlighted the unsatisfactory recording of physical examinations by trainees and point out that due to the general trend to specialise immediately on registration, trainees have limited opportunity to consolidate their medical skills. Perhaps one reason for this is the high level of medical responsibility expected of trainees (especially while on call) which tends not to be supervised by senior colleagues.

Although the number of admission requests and subsequent admissions is roughly equal in both schemes, Fig. 1 shows that in Sheffield PD felt it more appropriate to defer five (22%) admission requests, c.f. one (6%), in Chichester. This different pattern of 'disposal' may reflect personal clinical practice on the part of the trainee. It may also reflect differing GP practices and the type of mental health service provided during normal working hours.

The Sheffield scheme gave the trainee the valuable experience in assessing patients in casualty and on medical and surgical wards which was not available in Chichester (while on call). There was also the potentially useful experience of being second-on-call, but during the five days involved PD received only two calls for advice or guidance from the pre-registration House-Officer. There are three possible explanations for this: the house-officers find no difficulty in coping; when problems arise they perhaps bypass the Senior House Officer/Registrar and contact more senior colleagues direct if advice regarding formal detention of a patient is necessary; or they had no calls on the days concerned.

The experience in Chichester included acting as the designated nominee for Mental Health Act purposes. This resulted in KR using Section 5(2) on two occasions over a seven month period. From our own experience in previous schemes and from discussion with other trainees, it is generally viewed as invaluable actually to have the responsibility of using the Mental Health Act. This is perhaps more pertinent for trainees who have spent all their training period in a large teaching centre. When they do obtain senior registrar posts and subsequent approval under Section 12 of the Mental Health Act, they have personally never had the responsibility of placing a patient under a Section.

In conclusion, when comparing these two different schemes and their associated on call-duties, we found that there were four times as many calls in the peripheral rotation, and that 49% of these were for medical problems which required the trainee's attendance in 89% of cases. The number of admissions was similar in both schemes, even when corrected for the total population covered.

In Chichester the trainee acted as the consultant's nominee for the Mental Health Act, resulting in his using Section 5(2) on two occasions. We feel that this experience is very useful and is generally only obtained in more peripheral schemes.

Although different types of experience are available in each of the schemes, our findings suggest that the trainee in the peripheral scheme receives more calls (particularly non-psychiatric calls) and is busier than his counterpart in the teaching scheme. These findings highlight the point of different experiences and their appropriateness for general psychiatric training.

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