Failing the Part I Clinical

DEAR SIRS

Having examined four cohorts of trainees over the past two years, and discussed our assessments with other examiners, a reasonable consensus emerges that failure at this important level is most frequently the result of serious errors in one of two basic skills.

Time and time again we have seen trainees fail to make safe and systematic assessments of suicidal risk, and when relevant, homicidal risk. This obviously is a very worrying deficiency and invariably fails the trainee, however satisfactorily the remainder of the clinical is carried out.

To prevent such serious and unnecessary errors we would recommend that clinical tutors allocate structured teaching time to this aspect as part of interview skills training and that trainees not be encouraged to proceed to Part I until they have demonstrated consistently high levels of skill in this area.

The second major cause of failure is in the area of basic descriptive psychopathology. Trainees sometimes do not seem to know the appropriate stem questions for eliciting key psychotic symptoms, get side-tracked or confused when trying to clarify the exact nature of the phenomena they have elicited and then occasionally misclassify what they have elicited.

To remedy this deficiency we would recommend that all training schemes have a key person, usually the clinical tutor, trained in the use of PSE, and subsequently all trainees are given training in the use of the tool prior taking Part I. This would undoubtedly be a major undertaking, probably requiring an initiative from the College, but would do a great deal to ensure a uniformly high level of skill in an essential skill and save a great deal of grief and financial inconvenience for the prospective Part I candidate.

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Junior doctors' workloads in psychiatric hospitals

DEAR SIRS

We write in respect of the present on-call load of junior doctors within psychiatric services. This has recently been examined from two most pertinent angles. Firstly, if one may divide this so crudely, the angle of service delivery as outlined by Kingdon & Szulecka (1986) in their description of a consultant based service in Bassetlaw; secondly, from the viewpoint of the experience obtained by junior psychiatrists in a paper describing a comparison of on-call experiences by Donnelly & Rice (1989). Locally, consideration of future district plans for the delivery of mental health services is an on-going procedure and in our district, as in many others, focuses in the years ahead on the development of comprehensive provisions of service away from the traditional large mental hospitals. The service envisaged is a mixture of district general hospitals and community based units. Central planning is complex and multifaceted taking in everything from bricks and mortar needs to plan man-power needs. It was in respect of this latter question that attention was drawn to the provision of cover, particularly out of hours, for scattered units and how this may be achieved. This led us to survey the current workload and experience of the on-call doctor at mental hospital base. We present our experience and consider some implications.

The survey itself was conducted over a three month period between 1 March and 31 May 1988, by asking all the junior doctors involved in the on-call rota at Hollymoor Hospital to carry with them a daily log sheet of their work out of hours and to submit it at 9 o'clock the next morning after their period of on-call work, to us. There was a 95% return rate of these sheets which consisted of a simple check list to be completed for each out of hours contact. The check list included provision for where the call came from, at what time the call occurred, whether this call necessitated a visit and, in which case, the nature of the visit.

Hollymoor Hospital itself is a 363 bed psychiatric hospital offering a full district service with an average bed occupancy during the three month survey of 90%. The catchment area covered by the hospital consists of a mix of inner city and suburban wards with a total population in the order of 230,000.

The findings were as indicated in Tables I and II. In considering the implications, the style of the workload can be divided into that requiring some degree of psychiatric training and expertise, such as the assessment of mental state, particularly on admission, work involving the Mental Health Act, or the adjustment of psychotropic medications. Another category of work consists of the assessment and treatment of physical illness or injury and non-Mental Health Act administrative work. This division has important implications for who may provide future on-call service as well as requesting on the questions raised by Donnelly & Rice on the training nature of existent on-call.

Overall it appeared that the on-call doctors spent approximately 20% of their time while on-call actually involved in work. Over a period between 5 p.m. on Friday and 9 a.m. on Monday the workload was increased. Although this may be expected, the figures indicated that this increase was very largely made up of expanded work requiring psychiatric expertise within the acute wards of the hospital. It