Trainees' Forum

Psychiatrists' Views on their Preregistration Year

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Since its introduction in 1953, the preregistration year has been divided equally between medicine and surgery. The General Medical Council has recently shown renewed interest in possible modifications to this time honoured scheme.[1] One pilot scheme at St Mary's Hospital[2] in London has successfully incorporated a four month period of general practice in the preregistration year, reducing the preregistration medical and surgical jobs to four months each. Another pilot scheme in Sheffield[3] involves four months of psychiatry, four months of general medicine, and four months of general surgery. A psychiatric perspective on possible changes in the preregistration year is included in a report that derives from a conference held by the Royal College of Psychiatrists, the Association of University Teachers of Psychiatry, and the Association of Psychiatrists in Training.[4]

What changes, if any, should be made in the preregistration year? One simple approach is to ask practising doctors which aspects of their preregistration year they found useful, and whether their preregistration experience would have been more useful had it had been modified in some way. This article describes the results of a questionnaire study carried out to assess the views of a group of practising psychiatrists on the usefulness of their own preregistration year.

Methods and results

A questionnaire was sent to all junior and senior psychiatrists who had clinical responsibilities at the Bethlem Royal and Maudsley Hospitals in June 1985; 119 questionnaires were issued, and 80 of these were completed and returned within two months (67% response). Of the respondents, 65 had completed their preregistration year in the United Kingdom, and their replies were analysed further. This group comprised 26 Consultants and honorary Consultants, 11 Senior Registrars and honorary Senior Registrars, and 28 Senior House Officers and Registrars. The replies of 15 respondents were not analysed further: 13 had spent their preregistration year (or its equivalent) outside the United Kingdom, and two had qualified in the United Kingdom prior to the introduction of compulsory preregistration jobs. Informal enquiries suggest that many of the non-respondents were also in these excluded categories.

Recipients of the questionnaire were asked to assess how valuable a part of their training each of their house jobs had been. There was a forced choice between 'very useful', 'moderately useful', 'marginal value only', and 'no use at all'. Space and encouragement was also provided for individual comments on positive and negative aspects of the preregistration posts. Recipients were also asked how long they would have spent as house surgeons and house physicians in order to have obtained maximum value from their preregistration year, being given a forced choice between 'more than six months', 'six months', 'about three months' and 'no time at all' for each job.

Most of the senior psychiatrists rated their surgical house job as a 'very useful' part of their training, while most of the psychiatric SHOs and registrars rated their surgical experience as 'moderately useful', with senior registrars occupying a roughly intermediate position (Table I). The difference between senior and junior psychiatrists in their views on whether or not surgical house jobs were very useful reached statistical significance at $P<0.01$, using χ^2 with Yates' correction.

TABLE I

	Surgical house job rated as:			
	Very useful	*Moderately useful*	*Marginal value only*	*No use at all*
Consultants	17	7	2	0
Senior Registrars	5	6	0	0
SHOs and Registrars	6	14	8	0
Total	28	27	10	0

$\chi^2 = 7.32$, $P<0.01$.

Most respondents made specific comments on the value of their surgical experience. Many respondents emphasised that they had deliberately chosen a surgical subspeciality that had been particularly relevant to their interests: usually neurosurgery, and less commonly paediatric surgery or casualty. Many respondents emphasised the general benefits of working on a busy acute unit: gaining confidence in one's own ability to work under stress, practising decision making, learning to take responsibility, and acquiring a range of practical skills such as suturing, putting up drips and managing fluid balance. A few respondents mentioned specific advantages of having general surgical experience: knowing how to evaluate and when to refer potentially surgical problems arising on the psychiatric ward; and

knowing enough about surgery to be able to talk informedly with patients who have had or will have surgery. A few light-hearted comments were made, including these two (both from consultants): "It taught me what surgery was about and put me off it for life", and "Orthopaedics has greatly improved my home carpentry skills".

Most of the senior psychiatrists felt that six months was the correct duration for a surgical house job, while most junior psychiatrists would rather have limited their preregistration surgical experience to about three months. The difference between senior and junior psychiatrists fell just short of statistical significance.

TABLE II

	Medical house job rated as:			
	Very useful	*Moderately useful*	*Marginal value only*	*No use at all*
Consultants	19	7	0	0
Senior Registrars	7	3	1	0
SHOs and Registrars	21	6	1	0
Total	47	16	2	0

Medical house jobs were mostly rated as 'very useful' (Table II) and six months was generally felt to be an appropriate time to spend as a house physician. There were no statistically significant differences between the views of junior and senior psychiatrists. Most respondents made specific comments about their medical experience. Many comments emphasised the importance of general medical knowledge in the assessment and treatment of psychiatric patients. Several respondents commented favourably on some exposure to neurology as part of their preregistration medical job. Many respondents had clearly enjoyed general medicine, and had gone on to do a number of postregistration medical jobs before entering psychiatry. There were only two adverse comments on medical house jobs: one related to an inadequate case load, and the other related to an overspecialised job with little general medicine.

Would their preregistration year have been more useful had it also included other specialities? Overall, 74% of respondents (involving 65% of the consultants, 73% of senior registrars, and 82% of the SHOs and registrars) indicated that their preregistration year would have been more useful had it included one or more other specialities, with general practice and neurology being the most popular choices. Fewer than a third of the respondents would have opted for the inclusion of psychiatry in their own preregistration year.

Is a three or four month house job long enough to be useful for training purposes? Of the junior psychiatrists, 83% answered in the affirmative, compared with only 46% of senior psychiatrists ($P<0.01$ using χ^2 with Yates' correction).

Were the recipients in favour of a preregistration year common to all doctors, or of a preregistration year that could be different for doctors planning to enter different specialities? A slight excess of consultants favoured a common training for all doctors, while a slight excess of SHOs and registrars favoured more flexibility, with senior registrars being equally divided. These differences did not reach statistical significance. A few respondents felt sufficiently strongly about this issue to write individual comments in the margin, mostly stressing the dangers of forcing newly qualified doctors to make a career choice too early.

Discussion

In modern clinical practice, the views of senior clinicians on particular treatments are usually accepted as authoritative only if backed up by the results of formal outcome studies. In the field of medical education, formal outcome studies are badly needed. In the absence of suitably controlled trials of different schemes of medical education, it seems reasonable to sample the views of a wide range of doctors on the strengths and weaknesses of their own medical education. After all, each doctor is an expert on his or her own biography, and might well be able to make a reasonable assessment of the influence of past training on present competence. Ultimately, the value of such autobiographical assessments will have to be judged against truly objective outcome measures. This study is only a pilot study. Without further studies, it is impossible to know whether the views of this sample of psychiatrists are fairly typical of British psychiatrists in general. Furthermore, it would be very surprising if there were not major divergencies between the views of doctors from different specialities.

Some of the results of this survey reflect well on the current preregistration training. The great majority of the responding psychiatrists felt that medical house jobs had been a very useful part of their training, and that six months exposure to general medicine had been about right. Views on surgical house jobs were less strikingly and consistently positive. Nevertheless, over 80% of the respondents considered their surgical house job to have been moderately useful or very useful, and a substantial minority favoured a full six months as a house surgeon.

The results were not all so favourable to the existing preregistration scheme, however. Some of the findings cast serious doubts on the adequacy of the existing scheme, at least for aspiring psychiatrists. Three main areas can be highlighted:

(1) *Too much surgery?* Of the junior psychiatrists who responded to the questionnaire, 59% felt that their preregistration year would have been more useful had they only spent about three months doing surgery, while a further 10% felt that they could have spent their preregistration year more profitably had they omitted surgery altogether.

(2) *Room for other specialities?* Of the respondents, 74% would have found their preregistration year more useful had it included one or more specialities besides general medicine and general surgery: general practice was the most commonly favoured option, followed by neurology. Increasing the number of jobs in the preregistration year would obviously involve a reduction in job length. Thus if general practice were to be included in the year, house officers might spend four months each in medicine, surgery and general practice (as in the St Mary's pilot scheme).[2] An alternative allocation, which would correspond rather better to the views of this sample of psychiatrists, would involve six months of general medicine and three months each of surgery and general practice. Over two-thirds of the respondents in this sample thought that shortened house jobs (three or four months) would still be long enough to be useful. Junior psychiatrists were more likely than their seniors to feel that short house jobs could be useful, perhaps because many of them had relatively recently experienced six month jobs split into two independent parts, e.g. a surgical house job split into three months of general surgery and three months of urology.

(3) *More flexibility?* Many of the psychiatrists in this sample felt that they had benefited by exploiting the flexibility in the present preregistration system, e.g. by choosing to do neurosurgery rather than general surgery, or by choosing a general medical job with a strong neurology component. Half of the respondents were in favour of extending this flexibility even further by providing a greater variety of preregistration schemes.

The views of the junior and senior psychiatrists in this sample differ significantly in several important respects. The junior psychiatrists were generally less enthusiastic about surgery (though equally enthusiastic about general medicine), were more likely to favour the introduction of other specialities into the preregistration year, and were more likely to favour greater flexibility in the preregistration requirements. In all these areas, senior psychiatrists were more likely to endorse the *status quo*. In general, senior registrars occupied an intermediate position between SHOs and registrars on the one hand, and consultants on the other. These systematic differences with seniority prompt two related questions. Firstly, are senior or junior psychiatrists better judges? Secondly, what accounts for the divergence in views? These questions will be considered in turn.

When junior and senior doctors differ in their assessments and recommendations regarding the preregistration year, should the views of seniors be regarded as more authoritative because of their greater experience, or should the views of juniors be given priority because recent experience is more relevant and more accurately recalled? This study provides some clues. Consider the evaluations of surgical house jobs. Over three-quarters of all grades of respondents took the opportunity to make individual comments about the ways in which their surgical experience had come in useful. Although senior and junior psychiatrists differed in *how* useful they found surgery, there was broad agreement irrespective of seniority about *what* had been useful. It is noteworthy that the ascribed benefits of surgery should be most obvious at an early stage of a psychiatrist's career. This is clearly the case for acquired practical skills such as suturing or putting up drips. Junior psychiatrists are also more likely to need to evaluate and refer surgical problems arising in psychiatric patients. It also seems possible that a 'baptism by fire' into working under stress and taking responsibility makes more of a difference in the short term than in the long term. If the benefits of surgery do accrue principally to SHOs and registrars, these junior psychiatrists may well be the best judges of the value of surgical experience for psychiatric practice. (Perhaps junior and senior psychiatrists agree on the value of medical house jobs because general medical experience remains useful for the whole of most psychiatrists' careers).

If the junior psychiatrists in this study do have grounds for their misgivings about the current preregistration scheme, why should these misgivings be less prominent in senior psychiatrists? Three answers seem plausible. Firstly, conservatism (or one of its correlates) may be associated with an increased chance of securing a senior post in the institution studied. Secondly, changes in the nature of psychiatry or general surgery may have eroded the usefulness of the preregistration year in the recent past. Finally, the study may have revealed a 'nostalgic drift', with doctors' evaluations of their own life experiences (including their training) becoming increasingly positive the longer ago those experiences occurred. This postulated drift could conceivably reflect differential rates of memory decay for positive and negative experiences. For example, memories of the benefits of surgery may be relatively more durable than unpleasant memories of sleepless nights, 'assembly-line' clerking for routine lists, and hours pulling on retractors. Alternatively, nostalgic drift could result from the progressive resolution of cognitive dissonance, as predicted by McManus *et al.*[5]

Given the arduous and effectively compulsory nature of the preregistration year, there have been remarkably few evaluations of its usefulness.[5] Presumably, the preregistration scheme has continued substantially unchanged for over 30 years because the relevant decisionmakers have judged the scheme useful and worth saving. If nostalgic drift exists, however, then a need for change might go unrecognised since the seniority of the relevant decisionmakers would render them relatively insensitive to the failings of the scheme. This possibility underlines the need for objective assessments of alternative preregistration schemes.

The present study, and others like it, can only generate hypotheses about what sort (or sorts) of preregistration scheme would be most useful. These hypotheses then need to be tested. Although some pilot studies have experimented with alternative preregistration schemes,[1,2,3] these studies are of limited value because of their small size, and because the candidates were partly self-selected. More useful information could be obtained from larger-scale follow-up studies in which newly qualified doctors were randomly

allocated to alternative preregistration schemes. For example, one particular hospital group could collaborate with local GPs to offer both traditional preregistration schemes (medicine plus surgery) and expanded schemes (medicine plus surgery plus general practice), and applicants for these jobs would have to agree to random allocation to either scheme (though they could still express within-scheme preferences). If the sample size were large enough, outcome studies could establish the relative merits of the alternative schemes for future GPs, future psychiatrists, future surgeons, and so on. Although time-consuming and expensive, formal outcome studies may prove to be as useful in improving medical education as they have been in improving therapeutics.

References

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Conference Report

*Conference for Psychiatric Tutors in Teaching Interview Skills**

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This was the first course run for clinical tutors and 21 of us rolled up clutching our videotape of an interview with a patient. The skills of the three course tutors, Professor David Goldberg, Dr Francis Creed and Dr Peter Maguire, were immediately obvious when they overwhelmed us from the beginning with their positive comments, direct eye contact and friendly empathic approach. David quickly desensitised our phobia of the subject and made clear, with precision, the aims of the course. We were to be both trainee and tutor in the groups that followed and were to use our own tapes as demonstrations. We were fed some research, as befits an academic department, which showed us how effective the techniques were and how long the good effects lasted.

We then split into three groups and experienced each of the course tutors in turn in a supervisory capacity. We quickly learned that our interview skills were in need of improvement and the new language (lack of control, over-focused questions, backing off from emotion, ignoring non-verbal cues, exhibiting premature closure) to name a few, flashed past at tantalising speed.

With David, we were forced to look at the needs of the patient in the interview situation. We came to realise how much our look, gesture and voice affected what the patient told us. We were firmly made to consider the type of questions we were asking; whether they were open, closed, short-cut or precise and what responses they would elicit from the patient.

With David, each second on the tape counted and we were amazed how much we could learn from a minute of recording. Then we spent a session with Francis, feeling we were in the presence of a very precise, orderly mind that has the following symbol imprinted on it.

This was a choice point, we learnt. There were many in each interview and the number of prongs was important in deciding how the interview should proceed. He showed us, by frequently stopping the tape, (under a bit of resistance from the group, who were beginning to get punch drunk) how much we allowed ourselves to get sidetracked in a normal interview. His visual aide, the "tools in the bag", (which he kept down on the floor beside him), helped us to understand how there was a way out of every interview difficulty (each one had its own "tool"). We got a clear message that without a concise *aim* to the interview, the end product would also be vague and lacking in essential information.

Then we switched tempo with Peter, who liked to let the tape run and who also liked the group to give answers. He told us that the trainees would always know the answers, if we asked them to contribute, which was very comforting to us beleaguered tutors. By now we had group cohesion and were happily pointing out each other's faults and suggesting solutions. Peter reminded us that the real expert in an interview was the patient, if only we would let him talk to us.

Talking to several tutors at the end I discovered that each was making rapid plans to use the new knowledge and to start running courses on interview skills. I certainly felt inspired. One plea though, course tutors; please, more handouts, so that we have something to refer to when we have left the comforting haven of your expertise.

The course will be running again this year and is highly recommended.

**Held at the University Department of Psychiatry, Rawnsley Buildings, Manchester Royal Infirmary, Manchester on 8 and 9 January 1987.*