Psychiatric Bulletin (1990), **14**, 677–685

Correspondence

Flexible opportunities for part-time training in psychiatry

DEAR SIRS

I became concerned last year when I learnt that the College was now taking the view that clinical assistant sessions could no longer be judged to offer equivalent training experience for the purposes of the MRCPsych examination.

It occurred to me that many married women's careers had survived as a result of the flexibility which these sessions had offered in the past.

I sent a questionnaire to all the women consultants in the South West Region (30) asking them to give me a brief outline of their career moves and if they had been clinical assistants, to indicate the usefulness of this grade to them personally.

I had 24 replies and 15 had used the clinical assistant grade either as a stop gap for temporary periods or for longer term employment.

They described the advantages of these sessions as follows:

(a) an opportunity to remain in the specialty while a husband was climbing his own career ladder (one doctor described herself as a "camp follower")
(b) time to both care for a family and to study for examinations
(c) possibilities to match the school week timetable
(d) special training opportunities not available through training grades. (This seemed to be especially true of the South West Region where isolation and geographical disturbance featured as a training problem)
(e) a preferred income which contributed to child minding cost.

I asked them to describe the problems which they might anticipate in today's training schemes and the following points were made:

(a) part-time training posts require advocates and persistence
(b) there can be long waits for the DDC Scheme, both for manpower approval and funding
(c) today's part-time training can be more demanding when the family are young.

They commented that clinical assistant sessions now represent "pairs of hands". This grade does not attract study leave and posts are becoming more isolated.

Generally there was a sense that part-time training posts must be a better option but without greater flexibility the hurdles seemed considerable. A tribute was paid by one doctor to the Oxford Regional Part-time Training Scheme where sessions could be increased or decreased according to need. I understand that this policy is also seen in some European countries.

Advice used to be given that a married woman doctor required seven years longer than her male counterpart to achieve specialisation. Are we ignoring this wisdom by tightening the rules for entry to the MRCPsych examination?

I would like to recommend greater use of the part-time SHO option and job sharing where appropriate. This could at least make it possible for the trainee to take Part I MRCPsych without too much inconvenience. However in the South West Region we are already being told that part-time SHO posts cannot be set up as supernumerary to the existing SHO posts and must be arranged under equivalent rules to the DDC scheme.

The part-time registrar option is likely to prove more complicated with the constraints of *Achieving a Balance*. (In spite of the proposed allocation of a percentage of posts to post part-time training).

The staff grade post is not the answer for the able career woman who can take on greater challenges and responsibilities.

I would strongly recommend therefore that the College addresses the problem of flexible training opportunities for married women. Otherwise I fear we will lose the contribution of able doctors who might otherwise choose to follow a career in psychiatry.

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DEAR SIRS

I am delighted to have had the opportunity to respond to Dr Mary Hinchliffe's interesting letter. I share her concerns for the limited opportunities

available for part-time training particularly at the SHO/Registrar level. Indeed, I have reluctantly come to the conclusion that the problems facing trainee psychiatrists who have young children are more formidable than they were a generation ago, as I trained on a part-time basis.

I deplore the potential loss to psychiatry of motivated recruits whose time spent in child rearing provides an experience which is far from irrelevant to any branch of psychiatry. I hope, in collaboration with the Dean, to arrange a meeting where the implications of part-time training and other related issues can be discussed and measures taken to provide a remedy.

ANN GATH
Registrar

Computerised audit systems

DEAR SIRS

I read with interest of the computerised audit system currently under development by Professor Marks (*Psychiatric Bulletin*, August 1989, **14**, 495) and would like to echo his comments that such systems make the process of audit easier. SafetyNet is now being established in several hospitals across the UK and provides a sophisticated but simple solution to monitoring/charting clinical progress (employing recognised 5 point scales) and staff interventions. Since the system was first outlined in the *Psychiatric Bulletin* (**13**, 677–679) it has been enhanced and now incorporates a module called ResearchBase (also written using Ashton Tate's Dbase IV).

ResearchBase (which is also available independently of SafetyNet) allows any user (without computer expertise) to add in rating scales and questionnaires for time-series data collection. The system handles non-branching and branching scales, all data types (data are automatically validated) and will be useful to anyone wishing to repeatedly administer schedules as part of a research project, or who wishes to speedily develop a custom built audit or case register system that collects the data and descriptions they have selected. The system can handle virtually unlimited patient numbers, and up to 99 separate scales each with up to 999 questions.

Once data are on the system they can be very simply transferred to SPSS PC+ (SPSS UK) for analysis. ResearchBase comes with complete ICD-9 codes and descriptors (around 5,000) and medication codes and descriptors (proper drug names drawn from the BNF). Both SafetyNet and ResearchBase run on standalone IBM compatible machines (AT 286 or 386 computers with hard disks running MSDos) and do not require Dbase IV. Anyone interested in SafetyNet or ResearchBase can write to me at 309 Gray's Inn Road, for more information.

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Discharge summaries

DEAR SIRS

We were interested to read of the brief computerised discharge summary reported by Wattis & Protheroe (*Psychiatric Bulletin*, June 1990, **14**, 330), in particular that 93% of GP's questioned preferred a short summary with the opportunity to request more detail.

For the last 12 months our psychogeriatric department has kept detailed case summaries based on Institute of Psychiatry guidelines and including DSM-IIIR diagnoses. One copy is filed in the case notes, a second on the ward to provide instant access should patients be re-admitted and case notes not immediately available, and, a third in the department for internal audit and reference. The GP is sent a prose style letter on one side of A4 with a note explaining that a more detailed account of the patient's illness, history and progress is available on request.

Since this has been the policy we have discharged 90 patients to 72 GPs (about 50% of those in the catchment area) and, as yet, nobody has asked for the detailed summary.

Studies of GPs' requirements of discharge letters suggest the brief style is most popular (Craddock & Craddock, 1989; Kerr, 1990) and although a proportion always claim to want more detailed information our experience is that this is not requested even when the offer is clearly made.

A standard computerised format will become essential for audit but there is a danger that using too brief a summary will result in oversimplified audit results that may not accurately reflect our workload and clinical dilemmas and we feel the more detailed summaries will provide a more useful database for this purpose. As Craddock & Craddock (1989) demonstrated, the requirements of GPs and psychiatrists differ.

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References

CRADDOCK, N. & CRADDOCK, B. (1989) Psychiatric discharge summaries: differing requirements of psychiatrists