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Trainees' forum

Training for an uncertain future

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Although psychiatry's future looks less and less likely to be in large psychiatric hospitals, trainees at SHO/registrar level still spend nearly all their time in them. Although the White Paper looks set to dismember comprehensive provision as we know it, few psychiatrists have experienced self-employment, and most are untrained in practical management skills. Although our consumers – as we must now view them – are getting more discerning about what services we offer, psychiatrists only see them *after* they become ill, and less able to decide for themselves.

A spell in general practice, as regular GP trainees, would change all this, and we are advocating it for SHO/registrar grade psychiatrists. This may be for six months or a year, negotiated with a trainer who would be sympathetic to the scheme. The psychiatry trainee would be an employee of the practice and paid through the FPC, who have no authority to question GP principals on their trainees' career intentions. In this piece, we shall give our reasons for believing why this would be worthwhile – both of us having trained in general practice before coming into psychiatry.

On a wider front, international initiatives are stressing the need for an increased primary care component in undergraduate curricula (Tudor Hart, 1985) although a UK hospital specialist may have experienced no more than two weeks of it as a medical student. This must be considered inadequate in all but a few specialties like pathology and anaesthetics, and particularly in psychiatry.

It is said to be an advantage to have done 'something else' before coming into psychiatry: but we would suggest that the 'something else' could itself be a part of psychiatry training. As well as general practice, research, neurology and probably several other specialties are all sufficiently valuable to be incorporated into our SHO/registrar rotations as individually arranged 'time out' activities. This would make the career path to psychiatry more attractive, and give an increased breadth of training.

Criticisms of the current training

This sort of variety would also move us out of the dreary monolithic institutions to which psychiatrists used to be confined, and almost banished. Hospital-trained psychiatrists are ill-prepared for working in community-based teams, and their detached phenomenological approach is increasingly out of touch with clinical, and consumer, demand. Practical management is of paramount importance, and training which is as institutionalised as patients once were is not the way forward (Freeman, 1983).

We would also take issue with the academic part of training, which should move towards a broader approach – rather than having trainees amass didactically delivered factual wisdom, and acquire skills through unquestioning clinical apprenticeship. The new MRCPsych examination has moved in this direction, but not as far as GP training – where equal emphasis is given to three central aspects: practical skills, attitudes and factual knowledge (Royal College of General Practitioners, 1972). Present psychiatric training conveys knowledge and skills, but largely neglects attitudes – consideration of which are vital in our work.

Attitudes are individual, and often private, but play an important part in day to day contact with both patients and colleagues. Some psychiatrists have a period of personal therapy which they see as part of their professional development, but the relationship between the psychodynamic and more scientific schools seems at least uneasy, and often openly hostile. This discourages a broad training and can reinforce some of the more rigid views held by psychiatrists. One profitable training exercise might be an extended t-group (commonly used for professional training of GPs), but easy access to personal therapy may be more valuable – as it might encourage more honest reflection and self-criticism than is perceived as permissible among one's peers. If this was actively encouraged, and perhaps financially supported, it would start to dispel the notion that personal experience of the psychodynamic therapies is only of use for those intent on careers in psychotherapy.

Why time as a GP trainee would help

General practice has changed its image more than any other specialty in the last 20 years, and it is now

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seen as the setting in which the majority of medical treatment is carried out.

The first advantage of spending time in it would be in giving an increased breadth of experience, without losing the foothold on the psychiatric training scheme. It should increase confidence about making therapeutic decisions – often swiftly – and following them through. It will also increase contact with undiagnosed psychopathology that we read or hear about but rarely see (Goldberg & Huxley, 1980).

Secondly, it would lend a different perspective which aids the understanding of different roles involved in referral of patients; there is nothing like being a patient to appreciate a good or bad doctor and there is nothing like being a GP to appreciate a good or bad consultant. Psychiatry trainees would learn two specific things here – what a GP expects of a consultant psychiatrist, and what a consultant psychiatrist can expect of a GP.

Thirdly, it may give an idea of "normality". One of the boasts of the general practitioner who carries out his own screening and preventive care is that he sees his patients when they are well. This includes daily contact with normal emotional reactions and seeing the widespread presentation of physical symptoms without organic basis. These are things a registrar sees only occasionally, and the number experienced in general practice makes it an excellent training opportunity. The breadth and variety of patient contact makes general practice a challenging situation – not least because one learns something of the sophistry and fallibility of both patient and doctor.

In working for the practice as a regular GP trainee, a junior psychiatrist will appreciate the many common endeavours GP and psychiatrist share. Indeed, each has a luxury that the other lacks: the psychiatrist has that of consultation time and the GP has longitudinal knowledge of social and family context, and an enduring relationship – often over many years. Only exceptional GPs can devote as long to a patient in crisis as a psychiatrist routinely does, while few psychiatrists will understand the full extent of a patient's background and family as the GP can. The latter is often not appreciated by the junior doctor.

A pilot scheme, DHSS funded, is running in the Southwest Thames Region – and we should stress the value of setting up such opportunities elsewhere.

Comment

We have presented some suggestions for registrar training; the climate is one of change, and we believe that broadening it is the way to accommodate and adapt to those changes, particularly as we move into the community. Otherwise, we feel that the profession is vulnerable to schism into two types of psychiatrist, both of whom would be the poorer for it. We do not see this 'breadth of experience' as a dogma to be forced on all trainees – rather as an enabling framework through which they can wend their own career paths.

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