



the columns

correspondence

Psychiatrists and the pharmaceutical industry

I am sure I am not the only doctor to be offended by Dr Shooter's extreme comments about the relationship between psychiatrists and the pharmaceutical industry. I am not for sale, but I am of course open to influence – although is there much to choose within a class of drugs anyway?

Why is he sickened by the sight of doctors having a few days off to enjoy peer support and education (which might or might not be focused in some way). We get precious little informal time together otherwise.

There is another view: doctors are part of society, we are not morally superior. I live in a society where there is advertising and private industry: there is no clear moral argument for the pharmaceutical industry and doctors to be different from other people.

Dr Shooter's well-known eloquence has been taken to extremes in this matter. There seems to be a growing trend for links to industry to be regarded as intrinsically and inevitably bad, instead of one of many influences to which we are subject.

I have received sponsorship and hospitality from several companies. I minimise my own bias by having as many different mugs as possible!

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In defence of MRCPsych

The February 2005 issue of *Psychiatric Bulletin* contains several articles about the future of psychiatric training.

A specialist should not only be competent in the day-to-day clinical aspects of a speciality. We should have knowledge of the underlying science from which new ideas might develop, the social system in which we practise, and aspects of related medical and non-medical fields. These should co-exist in the individual. How easy will it be for an educational supervisor to assess these?

May I propose a novel competency-based assessment? We could have a target such that trainees (call them candidates) are expected to have a breadth and depth of theoretical knowledge and to be able to apply this to clinical situations in an appropriate manner. This could be assessed by a mixture of written answers to set questions and a series of simulated clinical situations. This process could be called an 'examination'.

How easy will it be for supervisors to 'fail' a trainee who, although adequate in the job does not have these other qualities? The College has rightly taken a lead on institutional racism. A central examination system (perhaps with some on-the-job assessment) may be a better safeguard against discrimination and recrimination than a relationship-based assessment – and protect both the assessor and the candidate from false accusations.

Medicine is practised in stressful situations, with limited time and competing needs. Perhaps an examination is not a bad test of this.

Incidentally trainees with extensive clinical experience in addition to theoretical knowledge are likely to succeed, those whose training has been too superficial may not.

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Specialist registrar training – our perspective

We read with interest the article by Vassilas and Brown (*Psychiatric Bulletin*, February 2005, **29**, 47–48). Having trained in the West Midlands region we feel the article gave a limited view of the current situation. What particularly concerned us was the point regarding the 'phenomenon' of senior house officers (SHOs) becoming staff grade and associate specialist grade (SAS) doctors.

It may be helpful to give our perspective on the current situation. In highlighting their experience of the training scheme, the authors have not mentioned that the current funding crisis has resulted in the restriction of adult psychiatry specialist registrar (SpR) numbers for the

past year. Lack of information from the deanery regarding this situation has left many of us demoralised and exasperated. This uncertainty has led to some taking SAS posts while awaiting an increase in the numbers of SpR positions.

We do not deny that pay is an important factor, but this may not be the main reason for taking SAS posts prior to SpR training. Some SHOs do not feel ready to immediately enter higher training and believe the opportunity to work at a staff grade can assist by providing more experience and responsibility. This is an issue that warrants further investigation.

As entry onto the West Midlands SpR rotation in adult psychiatry has become more competitive, emphasis has been placed on candidates having research or publications in order to be short-listed. If the authors' views are representative of the region, it is disheartening that we are expected to engage in research to enter a scheme that appears not to support research at this level. A survey of SpRs (Vassilas *et al*, *Psychiatric Bulletin*, 2002, **26**, 313–314) revealed that none felt the research day should be abolished and half felt the day was not used satisfactorily due to a lack of supervision.

We do agree that the future of SpR training is at a crossroads, but the views of trainees should be considered in this debate.

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The place of research in the training of psychiatrists

Vassilas and Brown (*Psychiatric Bulletin*, February 2005, **29**, 47–48) rightly state that very few consultants will be active researchers but that all require audit and critical evaluation skills. They go on to question whether one-fifth of higher training should be spent in research days of dubious benefit, and suggest that trainees might more profitably spend time in teaching and management. These are obviously important aspects of training,



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but I would suggest that they have less relevance to audit and appraisal than research. Indeed, it is all too often forgotten that clinical audit uses standard research methods and will generate unreliable results unless carefully designed (Lawrie & Sandercock, 2004).

One of the main problems with the higher trainees research day as it currently operates is that it is often inadequately organised and supervised. Most trainees would gain a lot more from a 4- or 6-month slot in full-time research as part of a research group, and this would constitute only a ninth or a sixth of a 3-year training programme. Such attachments could be allocated to those who requested them, as other training posts are at present. Overall, this would probably increase the numbers of psychiatrists with research skills; this would be important not only for audit but also for the promotion of research of direct clinical relevance. If our practice is to be influenced by more than politics and fashion, we need more research in psychiatry rather than less.

LAWRIE, S. M., SANDERCOCK, P. (2004) Epidemiology and research methods. In *Companion to Psychiatric Studies* (7th edn) (eds E. C. Johnstone, D. G. C. Owens, S. M. Lawrie, et al) pp. 65–184. Edinburgh: Churchill Livingstone.

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Research for the sake of research

I wholeheartedly agree with the views expressed by Nicola Phillips in her letter 'Who wants to be a specialist registrar?' (*Psychiatric Bulletin*, March 2005, **29**, 115). One of the biggest worries one has when applying for specialist registrar posts is the absence of research experience on one's CV.

Research is clearly very important for the advancement of psychiatry or for any other specialty for that matter. It is also important that trainees be encouraged to do research work. But does every single trainee have to do research work? Not everybody has the same aptitudes and interests; research for the sake of research is not very helpful. Some trainees are more interested in being good clinicians or have other special interests. For example, a special interest in psychotherapy should be given the same weight as one in research.

It is also time to consider the research day that all registrars are given. It might not be the most effective use of time for someone who is not interested in research. As much as science needs good research, patients need good clinicians and psychiatry needs professionals with different interests.

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A case for the 4-month SHO post?

With Part II of the MRCPsych examination rapidly approaching, I wonder how far the College has gone in considering reducing the length of training posts to 4 months from the current 6.

Several medical rotations have already embraced this approach in order to provide breadth of training within the limited time available. There seem to be several reasons why this approach might also be suited to psychiatry.

First, having completed the required posts for examination entry, including 6 months in neurology, I am soon to enter my 4th year as a senior house officer (SHO) and would still benefit from experience in forensic, psychiatric intensive treatment unit, perinatal and specialist addiction service roles. Four-month posts would allow all of this experience to be gained within 3 years, and allow time to be spent in research prior to entry into higher specialist training.

Second, competitive posts along with those required for examination entry can at times be in short supply and there will be a continued need for suitable placements to be found for general practitioner trainees, pre-registration house officers in their 2nd foundation year and perhaps in the future SHOs in medicine/neurology. Shorter posts should reconcile some of these competing demands if staffed appropriately while at the same time: (a) increasing exposure to psychiatry among other medical professionals, and access to medicine/neurology among psychiatric trainees; (b) decreasing stigma via familiarity; (c) facilitating recruitment; and (d) reducing some of the historical barriers between psychiatry and the rest of medicine that seem so much of an anachronism today.

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Moving consultant post

Dr Smithies writes about her experience in moving consultant post (*Psychiatric Bulletin*, February 2005, **29**, 65–66). We compared the characteristics of consultants who remained in post (stills) with those who moved to a new post (movers) using two surveys of workload and stress in consultant old age psychiatrists (Jolley & Benbow, 1997; Benbow & Jolley, 2002). Of those who contributed to both surveys, one-quarter changed post over 4 years. Movers did not differ significantly from stills in relation to age, gender,

marital status or work pattern. Individual doctors described similar stress levels in both surveys, suggesting that stress profiles remain stable. Movers were slightly younger than stills, and more often came from small teams, rather than working alone or in a larger team (but these findings were not statistically significant). Measures of stress in the second survey did not differentiate between the groups.

The mobility of consultant psychiatrists is an important feature of National Health Service practice. Moving is not, however, associated with an abnormal stress profile, or a change in an individual's perceived level of stress.

A mobile workforce brings with it advantages and disadvantages. Bringing new ideas and approaches from one culture to another is enlivening and stimulating. It avoids the risk of staff losing enthusiasm through boredom and sameness. For patients and carers, it reduces the risk that institutionalisation will mask, conceal, excuse or condone poor or exploitative behaviour. However, too much change can be counterproductive: promoting uncertainty and undermining confidence, and reducing the efficiency derived from established interpersonal links.

BENBOW, S. M. & JOLLEY, D. J. (2002) Burnout and stress among old age psychiatrists. *International Journal of Geriatric Psychiatry*, **17**, 710–714.

JOLLEY, D. J. & BENBOW, S. M. (1997) The everyday work of geriatric psychiatrists. *International Journal of Geriatric Psychiatry*, **12**, 109–113.

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The objective structured clinical examination

The case for and against the objective structured clinical examination (OSCE) has generated many interesting letters in the *Bulletin* recently. The unequivocal and emphatic response by Mortimer & Lunn (*Psychiatric Bulletin*, December 2004, **28**, 458) is welcome. It is clearly 'here to stay' (apology unnecessary, in my opinion).

The pros – examination of a broad range of scenarios, reducing the luck factor – outweigh, I feel, concerns about limited time and the fostering of 'fast psychiatry' (Yak et al, *Psychiatric Bulletin*, July 2004, **28**, 265–266). It is a useful addition to the examination format. However, concerns about the challenge of handling the long case format deserve a response.