

more rigorous than most, which involves their work in the psychiatric emergency clinic. Emergency rooms, both psychiatric and general, throughout American hospitals reflect a societal trend, most marked in the US, of rapidly accelerating figures for crime, especially violent crime. It is certainly true that the general incidence of crime is rising in most Western countries, but all fall far short of America, where the increase in violence is well documented to be approaching an exponential curve. This inevitably produces a social tension which rests uncomfortably in large hospitals. Johns Hopkins maintains a rigid security screen for all persons entering the hospital buildings and uniformed officers are carefully visible. Residents face violent patients, often under the influence of alcohol or drugs, and not uncommonly armed, to a much greater degree than their contemporaries in the UK.

This emergency work is compounded by another societal trend, that of successive Health Administration policies in recent years to empty long-stay psychiatric hospitals. There is recent, though admittedly controversial, evidence that many so-called street people, that is people adrift in cities with no fixed abode, are chronically mentally ill. Such

patients almost always lack health insurance, a fact which institutions like Hopkins finds embarrassing, if not a confounded nuisance. Residents tend to expend much time and effort despatching such individuals to local State hospitals, which are already so overcrowded that some will not easily accept voluntary patients, despite their obligation to do so. Such covert policies, therefore, encourage the liberal use of compulsory orders, not always in appropriate circumstances.

Inevitably I have drawn attention to the features which highlight the divisions appearing in American psychiatry. Such a polarization produces situations where each side seeks affirmation of its own views, in turn suffering a loss of self-esteem when its tenets are dangerously at risk, or actually abandoned. In public debate, therefore, the two approaches are wide apart. In practice, clinicians continue to borrow from a wide range of theory. Many of the residents at Johns Hopkins, despite their particular bias, remain interested in other schools of thought. What they do not seem to fully appreciate is how far they have travelled down the biological road.

Part-time Training in Psychiatry: A Personal View

RHINEDD TOMS, Senior Registrar, Severalls Hospital, Colchester

In 1975, seven years after registration, I had two small children and a part-time post as Staff Medical Officer with an Area Health Authority in London. For various personal and medical reasons I had decided to have a family early in my marriage. I felt it right that their upbringing should be largely done by me, and the alternative, if I worked full time, would be to hand over their care to someone else. I knew, however, that I should not be satisfied with a purely domestic role and part-time work in occupational health provided a compromise at the time. But I was uneasily aware of the lack of a definite goal and of my own doubts about continuing long term in this type of work.

My complacency was shattered by a move to Essex as a result of my husband's change of job. Occupational health services there offered few openings and the recent Court Report made the future of community health medical officers look uncertain. I was aware of the schemes which existed to help women in my position to retrain part-time in hospital medicine or general practice, and in my occupational health post I had been interested in the amount of time taken off work because of psychiatric illness. We settled in a part of Essex which had several large psychiatric hospitals, and my choice of specialty was made.

The first step was surprisingly easy. I called on the clinical tutor in the local general hospital who immediately put me in touch with his counterpart in psychiatry. Later the same day I was explaining my aim to the chairman of the Psychiatric

Division who was intrigued and sympathetic. I wrote to him officially, requesting a supernumerary training post in general adult psychiatry under the retraining scheme for doctors with domestic commitments, disability or ill health, and the application began its progress through the system, being dealt with largely at Area Health Authority level.

I was prepared for a delay of some months but in the meantime worked in various locum posts, thus gaining almost a year's experience in psychiatry before the supernumerary post was approved. In April 1977 I started work as a registrar for five sessions a week. Implicit in the arrangements was the expectation that I should work towards the MRCPsych. I moved through the various units in the hospital, as did the full-time trainees.

From the start I found myself working as a member of a unit with responsibility for both short- and long-stay in-patients, as well as out-patients. I arranged my work so that I was in the hospital for part of each day. In psychiatry part-time workers are probably more common than in many other hospital specialties, so my position was not particularly unusual, and work was organized so that both full- and part-time doctors carried similar responsibilities. There were obvious disadvantages in that one was not always available to deal with patients' problems personally, but full-time trainees, too, were sometimes away from the hospital, at out-patient clinics, on courses and so on. Problems, apart from really pressing ones, tended to be kept until I could next

see the patient. On the other hand, because my training moved slowly it was often possible to be attached to a unit for more than the usual six months, and thus follow the progress of particular patients for a longer period, this being particularly important for out-patients and patients in the long-stay hospital wards.

My hours were generally 9 am to 1 pm but it was also necessary to do extra time when required. I would stay for afternoon teaching sessions and unit meetings, leaving around 4 pm to collect my children from school. An on-call commitment had to be fitted in, and as the hospital operated a 24-hour system I found it easier to arrange to do this at weekends and holiday times when support was available at home.

Preparation for the MRCPsych proved difficult. Apart from the limited time available for study, I found it hard to return to concentrated academic work after a gap of over seven years. The examination format had also changed dramatically and I now had to grapple with the totally unfamiliar multiple-choice system. However, after the Preliminary Test was overcome in 1978, life in all these respects became easier. My children, now older, seemed to accept the fact that I disappeared to study for some of the time, and work for the 'eleven plus' and the MRCPsych progressed side by side.

I was fortunate in being allowed study leave and opportunities to attend courses in the same way as the full-time trainees.

After three years' training half-time I would have liked to increase my sessions, but the financial constraints then creeping in might have made this difficult. I was, however, offered two sessions in psychotherapy which had fallen vacant, and these, apart from shortening the overall training period, provided me with invaluable extra experience in this speciality.

Following the MRCPsych which I took in 1981, the next hurdle was to obtain a senior registrar post. Although domestic commitments were no longer so demanding, I was still geographically tied to my home area. This element in the debate about part-time jobs has not been sufficiently emphasized, and is often a more important factor than the time one has available. In my own case I felt I could now offer more sessions at senior registrar level, but would still want a post within easy reach of home.

By this time the regulations for part-time training as a senior registrar under the same scheme had been altered in several important respects. One aim of the new arrangements was to ensure that those able to train only on a part-time basis should find it neither easier nor harder to find a senior registrar post than did full-timers. The number of part-time training opportunities at senior registrar level was now limited, and if the number of applicants in any speciality exceeded the number of posts sanctioned, interviews had to be held in the same way as for full-time appointments. Furthermore, initial application for manpower approval

could only be made to the DHSS once a year, in the autumn.

As I had gained the MRCPsych in June, the delay before I could apply was not too great, but those passing the examination in December would have to wait almost a year before applying. The alternative would be to make a provisional application before taking the examination, thus decreasing one's chances of obtaining approval in competition with better qualified candidates. This loss of flexibility has meant a serious delay for some trainees. If manpower approval is granted a suitable post must be arranged within a specified time, otherwise the approval lapses and the procedure must begin all over again.

Following an interview in January 1982, I heard that I had been granted manpower approval for a senior registrar post in adult mental illness. This guaranteed nothing but enabled me to set in motion the procedure for creating a supernumerary post. Applications had to be made, educational approval sought and, above all, funding had to be found. A 'gestation period' of nine months was allowed, and I soon found myself longing for early delivery!

I had wanted to continue training in the same district but a link with an academic department of psychiatry was necessary. An approach to a London teaching hospital resulted in an agreement to provide training for two sessions a week. Funding of the whole post had, however, to be provided by the District, as the Region was unable to find the money for the post, and this promised to be a major obstacle. Perhaps the procedure was eased as I was already employed for seven sessions per week and the money I was already being paid could be set against the new sum required. I am sure that my path was also smoothed as I was already known to the District, and the concept of part-time training was not a totally alien one. I also received enormous support from the clinical tutor, who worked tirelessly on my behalf, and the chairman of the psychiatric division. A part-time trainee armed with manpower approval, but having to approach a district where she was not known, would have had to face far greater difficulties. Although I had hoped to work for seven or eight sessions per week, funding was eventually available for only six, plus travelling expenses, and with this I had to be content.

The next step was to obtain approval for the training programme from the Joint Committee on Higher Psychiatric Training. An outline programme was initially rejected as not being detailed enough, but helpful guidelines were given and a second programme was accepted with only a few weeks to spare before manpower approval came to an end.

There was one final hurdle in the form of an interview by a local appointments committee so that my suitability for the proposed post could be assessed, and just before the expiry of the nine-month period allowed I started in post as a part-time senior registrar in adult psychiatry for six sessions a week.

As a senior registrar I have had regular contact with the academic department of psychiatry at the London Hospital,

and though initially regarded as somewhat of a curiosity, I am gradually getting to know people in the department and becoming involved in their work. The range of duties in my main hospital is broadly similar to that of the full-time senior registrar, and inevitably work spills over into one's own time, as one would expect it to do.

A year into higher psychiatric training I am able to look back at the 'part time' problem. There has been endless debate about the rights and wrongs of devoting one's time as a medically trained woman exclusively to one's family or, alternatively, concentrating on one's career and transferring other responsibilities to someone else. Most women—and most part-time trainees are women—must make an individual choice and some, like me, will decide on what may seem to many to be an unsatisfactory compromise. On a personal level one needs determination, knowledge of what arrangements are available, and above all support and encouragement from family and colleagues. The actual organization of the job has created few problems apart from the extra load placed on my colleagues during periods of absence and annual and study leave. From the opposite viewpoint, though, I have been able to help with the work when I have been there, as my post has been surplus to establishment.

As far as the training is concerned, as a registrar I experienced all aspects of the job as do the full-time trainees. I found the studying difficult, but this is not exclusive to part-time trainees. I was not prepared for the problems and anxieties surrounding the application for a senior registrar post, and found the struggles to arrange this the most daunting of all.

I would have welcomed contact with someone else training in the same way for discussion of difficulties and support. The various articles published in the journals were useful sources of advice, although some were written from a very unsympathetic standpoint!

My domestic commitments have gradually changed in character over the years as my children have become more independent, but I am still geographically tied. When the time comes to apply for a consultant post I would now feel able to offer a full-time commitment to the specialty. In spite of its drawbacks, part-time training has been valuable to me during the time I have needed it. The scheme is a good one, but whether it will survive in the face of rumoured medical unemployment and financial stringencies remains to be seen. If it does not, the choice facing today's increasing numbers of female medical graduates will be even more stark than at present.

Psychiatric Advisory Service—Statement of Need

T. J. FAHY, Vice Chairman, Irish Division and Chairman, Irish Psychiatric Association

The Irish Division, through its Executive Committee, is pursuing a policy of pressing for early consultation with the Department of Health on Irish national issues bearing directly on the welfare of the mentally ill. Part of this policy is to publish from time to time selected position papers of significance which have been submitted to the Department. The following paper advocates the monitoring of psychiatric services in the Republic of Ireland by peer review with tentative suggestions as to how this might be achieved. In a slightly different form this paper was submitted to the Department of Health in March 1983 without, to date, formal response.

Until recently, civic visiting committees and Department of Health Inspectorates have served as safeguards of good standards of care for the mentally ill in the Republic of Ireland. However, standards in some Irish psychiatric services were noted to be poor in the College's approval exercise. Even new legislation now pending does not provide any further safeguard other than against unfair detention. A new approach is needed which will safeguard standards and will command the confidence of the caring professions and of the public at large.

All professions traditionally are self-monitoring, but ordinary professional discipline is inadequate for this purpose in relation to psychiatry for several reasons:

- (1) Psychiatric procedures are based on a wide range of techniques of intervention and accommodate a wide variety of behaviours, both in the doctor and in the patient. This variety makes it difficult for the consumer to know good from bad practice.
- (2) Psychiatric patients are sometimes irrational and may be compulsorily detained for treatment; they are thus badly placed to monitor their doctors compared with other medical patients.
- (3) With few exceptions, Irish psychiatric facilities are isolated from general medical care. There is a consequent tendency for practice to become idiosyncratic and eccentric. This tendency is aggravated by lack of knowledge as to the best way to proceed, particularly in community settings.

These points are well illustrated in recent British experience of statutory inquiries, fire scandals and maltreatment of