British Journal of Psychiatry (1990), 157, 335–338

Is Psychiatric Training Still Improving?

PETER BROOK

A postal questionnaire inquiring about postgraduate training was directed to all consultants appointed to a post in general psychiatry for the first time between 1 October 1985 and 30 September 1986. Compared with previous surveys there is, overall, more expressed satisfaction with training in psychogeriatrics, supervised ward consultations, individual psychotherapy, work in the community, and with medico-legal experience. Diminished satisfaction is expressed in training in child and adolescent psychiatry, epidemiology, psychology, and neurology. An improved system of monitoring by the Royal College of Psychiatrists and the Joint Committee for Higher Psychiatric Training is suggested in order to further improve training.

From 1971 until 1982 all recently appointed consultants (NHS and honorary) who were working in general psychiatry and its associated specialities – psychogeriatrics, rehabilitation, and substance abuse – were asked their views as to how satisfactory their training had been. These postal inquiries, made at three-year intervals, eventually covered all general psychiatrists appointed between 1 October 1966 and 30 September 1981. The five cohorts will be referred to as the 1970, 1973, 1976, 1979, and 1982 groups (Brook, 1972, 1974, 1977, 1980, 1981, 1984). There was an initial improvement in expressed satisfaction with training compared with the results of an earlier, slightly different survey of consultants appointed during 1963–66 (Royal Medico–Psychological Association, 1969). There was little change until the 1979 survey, which did show some general improvement, a trend more clearly delineated for the 1982 group.

In the time covered by these surveys, two changes were introduced to improve postgraduate training. The Royal College of Psychiatrists, the successor to the Royal Medico–Psychological Association (RMPA), was founded in 1971. One of the College's first acts was to institute a membership examination, and over the next two years every hospital in the UK offering training was visited to assess its suitability for preparing young doctors for the examination. These visits have continued at regular intervals ever since. Guidelines for accreditation, based on those prepared by the RMPA, were formulated in order to help approval teams arrive at appropriate judgements. Over the years these standards have been progressively raised (Royal College of Psychiatrists, 1985).

The Joint Committee for Higher Psychiatric Training (JCHPT) was established in 1973 with its membership drawn from the main educational bodies in the specialty, the College and the Association of University Teachers in Psychiatry. The functions of the Committee were to publish recommended goals and standards of higher training in psychiatry in all its major specialties and to inspect and approve training programmes. Its broad aim was to ensure that those in higher training were being prepared adequately for consultant posts (JCHPT, 1987). Guidelines were published in the JCHPT's first report (1975) and inspection of schemes was in progress by 1976. In succeeding years standards required for schemes to be approved have been steadily raised.

This paper reports the experiences of a two-year cohort of recently appointed consultants.

Method

A postal questionnaire was sent to all 175 trainees appointed for the first time to a substantive post in general psychiatry (including those in special-interest jobs) in the UK between 1 October 1985 and 30 September 1986.

Respondents were asked to report their experiences in 13 basic clinical areas on a three-point scale:

(1) adequate in quantity and adequate consultant supervision
(2) adequate in quantity but inadequate consultant supervision
(3) inadequate or no experience.

They were then asked to rate 12 areas of special experience or academic teaching on a similar scale:

(1) sufficient in quantity, and well taught and properly supervised
(2) sufficient in quantity, but inadequately taught and supervised
(3) insufficient in quantity or none.

The wording of the two scales was as used in previous inquiries. The first 13 areas – identical to previous surveys except that the question on work in a therapeutic

https://doi.org/10.1192/bjp.157.3.335 Published online by Cambridge University Press

TABLE I

Percentages of newly appointed consultants reporting complete satisfaction with training in clinical areas

Items on questionnaires	*1987*				
	total (n = 125)	*trained in teaching hospital* (n = 66)	*trained in non-teaching hospital* (n = 59)	*UK graduates* (n = 103)	*Overseas graduates* (n = 22)
Interviewing techniques	54	59	49	54	55
Work with psychogeriatric patients	75[1]	74	78	80	59
Work with long-stay patients other than geriatric	54	52	56	56	41
Rehabilitation activities, e.g. occupational/ industrial therapy	35	35	36	39	18
Individual psychotherapy	72[1]	76	68	75	59
Group psychotherapy	58	59	58	61	46
Other methods of psychological treatment, e.g.:					
behaviour therapy, hypnotherapy	34	35	34	38	18
ward consultation in general hospitals	73[1]	73	73	72	77
treatment and management of the dependencies	61	59	63	58	73
emergency work (acutely disturbed patients in casualty depot or in patient's home)	67	70	64	68	64
medico-legal reports and sectioning	65[1]	64	66	66	59
Community work (including Part III accommodation, day centres and hospitals)	50[1]	50	51	50	55
Marital and family therapy	46	49	42	50	27

1. Notably greater than in the 1982 survey.

community was replaced by an inquiry about training in marital and family therapy – are listed in Table I. Table II gives the 12 areas of special experience; these are the same as in previous surveys except 'neurodiagnostic procedures' has been substituted for neuroanatomy and neurophysiology. In addition, respondents were asked to give their sex, and the medical school where they had obtained their original qualifications. They were asked to provide an outline curriculum vitae to determine the types of hospital where they had been trained.

As the results reflect opinion, formal statistical analysis was not considered to be appropriate.

TABLE II

Percentages of newly appointed consultants reporting complete satisfaction with teaching in specialised areas of experience

Items on questionnaires	*1987*				
	total (n = 125)	*trained in teaching hospital* (n = 66)	*trained in non-teaching hospital* (n = 59)	*UK graduates* (n = 103)	*Overseas graduates* (n = 22)
Psychopharmacology	72	82	61	73	68
Mental handicap	29	29	29	30	23
Children and adolescents (not subnormal)	49[2]	52	46	54	23
Forensic (prison, remand home, approved school, borstal)	45	49	41	47	36
Neurology	46[2]	46	46	44	55
Psychology	53[2]	55	51	55	41
Epidemiology	41[2]	47	34	44	27
Administration	22	26	17	20	27
Teaching (undergraduate)	62	71	51	62	59
Teaching (postgraduate)	57	62	51	59	46
Research	55	59	51	52	73
Neurodiagnostic procedures	33	36	29	33	32

1. Notably greater than in the 1982 survey.
2. Notably less than in the 1982 survey.

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Results

Replies were received from 145 doctors, of whom 20 proved to be ineligible; the final response rate of those falling within the scope of the survey was thus 81% (125/155), comparable with previous surveys. The present respondents are hereafter referred to as the 1987 group.

Twenty-two (18%) had qualified overseas, the great majority in the Indian subcontinent (1982 29%, 1979 26%, 1976 27%). Thirty-five (28%) were women (1982 19%, 1979 27%, 1976 20%).

As in the previous surveys, respondents were divided into two groups depending on the type of hospital (teaching i.e. university, hospital, or non-teaching) where they had received a majority of their training as a senior house officer or registrar.

Tables I and II give the 1987 consultants' ratings of their training and teaching compared with previous cohorts: only figures for the rating of adequate and adequately taught or supervised are given, as this is the standard for which training should be aiming. Less than half of the respondents reported complete satisfaction in: rehabilitation, other methods of psychological treatment, marital and family therapy, mental handicap, child and adolescent psychiatry, forensic psychiatry, neurology, epidemiology, administration, and neurodiagnostic procedures. The results of the previous surveys are presented in graphic form in Figs 1 and 2.

Discussion

Although there is a general trend towards improvement, progress apparently remains slow, posing questions about the Royal College's and the JCHPT's effectiveness in raising training standards. What must however be stressed is that all these surveys measured opinions only, so that what might have been regarded as satisfactory training experience ten years ago would now be seen as indifferent or even poor, owing to changing expectations because of the activities of the College and JCHPT. We are observing shifting standards as each cohort, especially recent ones, will have higher expectations as to what constitutes adequate teaching, thus blurring progress made as measured by the surveys.

As well as expectations, objective standards will also have been affected by the recommendations and inspections of the College and JCHPT. The standards of these inspecting and approving bodies have themselves risen over the last 15 years. A comparison of the JCHPT's first report (1975) with the most recent handbook (1987) makes it clear that recommendations have become more comprehensive, more detailed, and more precise. To take one example, a senior registrar who obtained a consultant post in 1988 at some time during training would have had at least six months' experience in child psychiatry together with formal lectures in that topic: 20 years ago very few newly appointed consultants would have had anything comparable in experience and training in child psychiatry. Examination of the figures indicates that it is since 1979 that most progress in training has taken place. Half to two-thirds of the doctors in the 1979 group would have started their psychiatric training in 1971–72 and in consequence would have benefited from the improved standards of training arising as a result of the efforts made by the JCHPT and the College. All those in subsequent cohorts would have had their training experiences shaped by the activities of these two bodies.

A further complicating factor is that consultant posts, especially in psychogeriatrics, have been expanding greatly in recent years but without a commensurate increase in the number of senior registrars. The consequence is that many senior

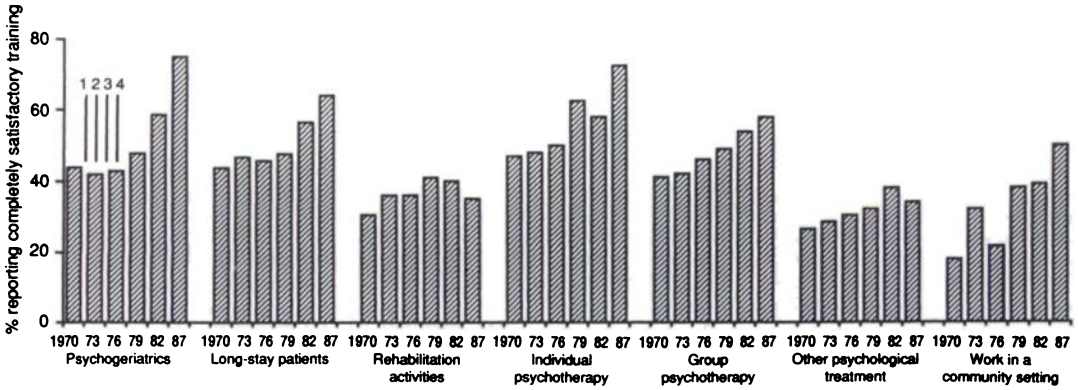


FIG. 1 Progress in psychiatric training in clinical areas, 1970–87. Note that in 1971 the College was established and in 1972 the membership examination and accreditation visits commenced; in 1975 the JCHPT published its guidelines, and in 1976 its approval visits started.

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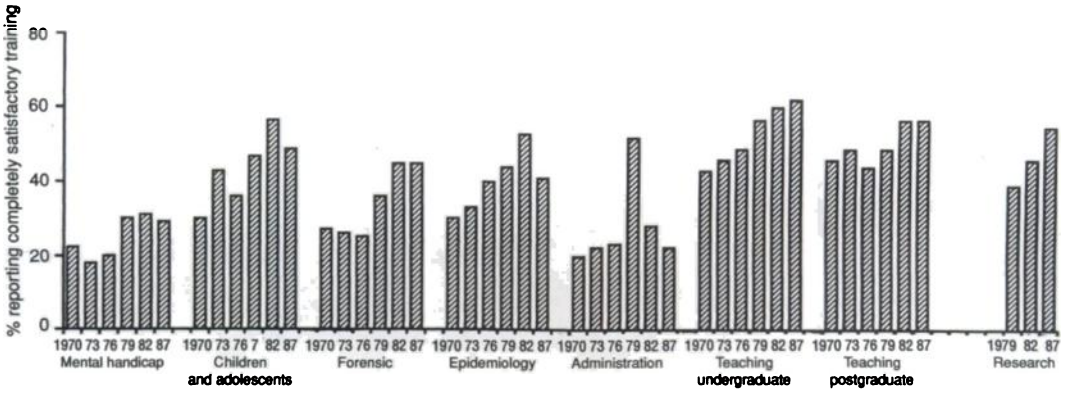


FIG. 2 Progress in psychiatric training in specialised areas, 1970–87.

registrars are appointed to consultant posts who have not completed a full training (Bewley, 1987).

Two final lessons can be drawn from the survey. The first is that there still exist differences between training in teaching (university) and non-teaching hospitals: these differences should disappear as more schemes incorporate rotation between both types of hospital, as a result of the recommendations made in *Plan for Action* (Department of Health and Social Security, 1988). The second is that there remains a continuing need for pressure by the College and the JCHPT to improve training standards generally and in certain areas specifically.

In order to achieve this aim the two organisations concerned need to improve monitoring of training and teaching. One way in which this could be done would be for trainees to rate their experiences at intervals, perhaps based on the questionnaire used in this inquiry. This would allow tutors and visiting teams to identify potential weak areas. Another way would be for senior registrars in conjunction with their tutors to identify any gaps or weaknesses while they were in training, and to set up 'learning contracts' to correct deficiences.

Acknowledgements

I would like to thank all those consultants who took part in the survey and Jane Boyce for her impeccable organisation of the survey. I am grateful to the DHSS, the Scottish Home and Health Department, and the DHS Northern Ireland for providing the names of consultants. Richard Wakeford, Senior Research Associate in the office of the Regius Professor of Physic, Cambridge, made helpful comments and suggestions. This project was funded by the Royal College of Psychiatrists.

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Peter Brook, MA, MD, FRCPsych, *Consultant Psychogeriatrician and Senior Registrar Organiser for East Anglia, Fulbourn Hospital, Cambridge CB1 5EF*

https://doi.org/10.1192/bjp.157.3.335 Published online by Cambridge University Press