Experience desirable for the general practice trainee occupying a senior house officer post in psychiatry.

LIAISON COMMITTEE OF THE ROYAL COLLEGE OF PSYCHIATRISTS AND THE ROYAL COLLEGE OF GENERAL PRACTITIONERS

Foreword

THE experience recommended in these guidelines must be seen as only one part of the total postgraduate training of general practitioners in psychiatry. Other opportunities arise in training practices and day release courses.

For some trainees there will be no experience in psychiatric hospital posts, for a variety of reasons. This emphasizes the importance of the other learning situations, since psychiatric understanding is vital in general practice.

The need for co-operation between regional and local advisers or tutors in psychiatry and in general practice extends, therefore, beyond the subject of these guidelines. It covers the distribution of experience over all the learning situations available to vocational trainees, and takes account of continuing opportunities for training after establishment in practice. Responsibility for ensuring this co-ordination lies with the regional advisers and scheme organizers in general practice.

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Introduction

Suitable hospital experience is recognized to be an important part of postgraduate preparation for general practice. The concentration of clinical material and the ready supervision by appropriately experienced colleagues can rapidly enhance clinical skills and help to bring about professional maturing with a general gain in competence and confidence. Firsthand knowledge of hospital procedures and of what hospitals can offer is of importance to general practitioners. At the same time a perspective on the relationship between general practice and specialist services is achieved from the hospital standpoint.

The following notes are intended as pointers to areas of knowledge and clinical practice in psychiatry with which general practitioners should be familiar, and to enable psychiatric consultants to help their general practitioner trainees occupying senior house officer posts to acquire a sound basis for their future practice of family medicine. The relationships established in this way can be of great benefit to both branches of the service, as well as to patients.

Local conditions will undoubtedly influence the way these proposals are implemented, and variety of approach is not only to be expected but welcomed. Close co-operation will be required between a number of individuals, particularly the regional postgraduate adviser in general practice, the Royal College of Psychiatrists' regional adviser, the local psychiatric tutor, and the vocational training scheme organizer.

The immediate objects of the general practitioner trainee and the trainee psychiatrist may differ in a number of important respects. For instance, the requirements of the respective postgraduate examinations are different and the emphasis on range and content of training also differs. On the other hand there are areas of knowledge and practice which are common and which, during the training period, could be shared to the advantage of both; it is in this connection that the consultant psychiatrist can be of particular help.

Apart from frank psychiatric illness, a significant psychological component is present in a large proportion of patients seeking advice from their family doctors, so it is an advantage for the trainee to have an opportunity of gaining wide working experience in the field of psychological medicine and mental health. In view of the ground to be covered a tenure shorter than six months might be regarded as less than optimal, but there is need for a study in which posts of different lengths are evaluated.

It must not be forgotten that certain essential experiences (such as psychiatric aspects of chronic physical illness) cannot always be covered in senior house officer psychiatry posts, but may be better acquired in other learning situations, such as the teaching practice.

Areas of experience

During a six-month tenure it should be possible to obtain worthwhile experience in the following areas:

1. General psychiatric practice including interview techniques, taking case histories, and making formal diagnoses.

2. Methods of psychiatric treatment, especially the proper use of psychotropic medication and of the more simple psychotherapeutic procedures.

3. Application of the Mental Health Act, with particular reference to the responsibilities of general practitioners.

4. Management of acute psychiatric emergencies.

5. Recognition and management of potential psychiatric emergencies.

6. Liaison with professional workers in the community, especially general practitioners, social workers, and community psychiatric nurses.

In addition the following areas should be covered, if not by actual clinical experience then by seminars, etc:

7. The long-term care of chronically disabled psychiatric patients.

8. Psychiatric aspects of the aged in the community.

9. Diagnosis and treatment of psychosexual conditions.

10. Counselling, for example in family crises and marital problems.

11. Miscellaneous areas of special experience such as child and family psychiatry, adolescent psychiatry, mental handicap, forensic psychiatry, and dependence on alcohol, tobacco, and other drugs.

1. General psychiatric practice

Introduction to general psychiatric practice, especially case taking, diagnostic procedures, and initial therapy, can best be achieved by the trainee being allocated to a psychiatric firm for a short induction period of a week or so. Some psychiatric hospitals and centres provide a short guide on medical administration, admission procedures, case taking, the Mental Health Act, postgraduate teaching programmes, etc., and this is much appreciated by newcomers.

On completion of the induction phase the work of the trainee as a member of the team, firm, or sector should include a range of duties involving care of short-term as well as long-term patients, in both outpatient and inpatient settings, and including the medical duty rota. These duties, which involve case taking, carrying out diagnostic procedures, carrying out treatments, interviewing relatives, and dealing with admissions, should be under registrar, senior registrar, or consultant guidance and instruction but with increasing clinical responsibility. The trainee could accompany the consultant on domiciliary visits from time to time.

Some trainees may find disturbed patients particularly stressful and should be able to look to an experienced colleague for the necessary support.

2. Methods of psychiatric treatment

The range of duties in apprenticeship suggested above will introduce the trainee to a relatively wide range of treatment procedures, the rationale of which will be explained by the supervising medical staff. Knowledge and experience is particularly necessary in connection with side-effects and interactions of various psychotropic medicines. In addition, knowledge of other methods, some practical experience in simple psychotherapeutic measures, and awareness of alternatives to inpatient care such as the day hospital is desirable.

3. The Mental Health Act

From time to time the general practitioner will be involved with the operation of the Mental Health Act. The senior house officer trainee participating in a full range of duties should gain practical experience in the application of various sections of the Act and in liaison with local social services departments.

4. Acute psychiatric emergencies

The range of duties should provide experience in recognizing and managing various acute psychiatric emergencies involving states of severe agitation and distress, impulsive acts, alcoholism, and suicidal attempts.

5. Potential psychiatric emergencies

The trainee general practitioner can obtain practical instruction in the recognition of such cases in the course of ward rounds and at postgraduate seminars and journal clubs. These cases include serious depressive conditions, atypical depressions and psychoses, and some types of drug abuse.

6. Liaison with community services

The trainee should be encouraged to take part in multidisciplinary case conferences, especially those attended by professional workers in the community such as general practitioners, social workers, and community psychiatric nurses.

7. Chronically disabled psychiatric patients

In view of the increasing number of chronically disabled patients now being cared for in the community by general practitioners, with or without community psychiatric services, the trainee general practitioner must be able to recognize the needs of such cases in order to arrange appropriate care, treatment, and rehabilitation (for instance by attendance at a day centre), or to arrange specialist advice and help. The trainee should have experience of patients receiving lithium therapy or depot injections of psychoactive drugs, and of methods of behaviour therapy for phobic conditions, alcohol dependence, etc.

8. Psychiatric aspects of old age

Because of the widespread problems involved in the care, management, and treatment of aged mentally disabled people in the community and in hospital, it is important that this area of experience be included among the duties of the trainee. Special attention should be paid to the recognition of depression, senile dementia and the physical and remediable causes of confusion. Experience should include a community setting and contact with appropriate community social agencies.

9. Psychosexual conditions

There are relatively few centres where specialist experience in the diagnosis and treatment of psychosexual conditions can be obtained, but in view of the frequency of such problems in general practice the trainee might obtain insight from the hospital or unit if suitable experience is available. It is also necessary for the trainee to be aware of the effects which psychotropic medicines may have on sexual function.

10. Family crises, marital problems, and counselling

The general practitioner can be confronted with emotional problems associated with serious physical or mental disablement, the effect of acutely distressing medical information, bereavement, marital conflict, and many other situations in which a counselling approach is appropriate. The trainee cannot however hope to obtain sufficient counselling expertise within a single psychiatric senior house officer appointment.

11. Special areas of experience

In his relatively short tenure the trainee general practitioner would not normally participate in the specialty secondment or rotations necessary for the trainee psychiatrist. However, any experience of child and family psychiatry, adolescent psychiatry, mental handicap, forensic psychiatry, or the treatment of dependence, though hardly representing more than an exposure, would nevertheless be helpful.

Postgraduate educational activities

The holder of a senior house officer post, whatever the specialty, is in training and must expect to supplement his in-post experience by a variety of learning activities, whether planned beforehand or *ad hoc,* both within the hospital where he works and outside. The postgraduate clinical tutor or the general practitioner course organizer can advise on the availability of such activities and may be in a position to organize an individual programme, including special attachments.

Full use should be made of libraries, both in the department and in the postgraduate centre. Every effort should be made to attend audit and patient management reviews in the department, interdisciplinary meetings, and clinicopathology conferences of wider interest.

The concept of general professional training implies that in-post teaching should primarily be about the specialty itself, whatever the incumbent's eventual career destination. However, those trainees in hospital who are preparing themselves for general practice possess, in the local day or half-day release course, an opportunity to maintain contact with their peers and to take part in a programme of group work during which their specialty teaching can be related to the wider perspectives of general practice.

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Addendum

Copies of these guidelines are available from the Office of the Dean of Studies, Royal College of General Practitioners, 14 Princes Gate, London SW7 1PU.

Perinatal and infant deaths

In each year perinatal mortality rates for children born in general practitioner units are less than one third of those for children born in consultant units. During the period 1975 to 1977 there has been a change in the relationship between the perinatal mortality rate for children born in consultant units and those born at home. In 1975 the perinatal mortality rate for children born at home was two per thousand lower than for children born in consultant units; in 1976 the rates were similar but by 1977 the perinatal mortality rate for children born at home was five per thousand higher than for children born in consultant units. A similar pattern is not repeated for postneonatal deaths, but it should be noted that the causes of death during the postneonatal period are very different from those during the perinatal period.

Reference

Davies, I. M. (1980). Perinatal and infant deaths: social and biological factors. *Population Trends 19.* Spring issue, 19-21. London: HMSO.