there are a number of common ingredients in most individual schemes. A 3½-year programme always includes six months on the Professorial Unit, six months in child or adolescent psychiatry and 12 months on a general adult firm; the remaining 18 months may be filled by six-month assignments to psychogeriatrics, mental handicap, the Regional Alcoholic Unit, or to one of the General Hospital Psychiatric Units. Provision is made for trainees with a special interest in child psychiatry by the inclusion of one 12-month placement in this field.

Theoretical instruction, psychotherapy training and research

Weekly tutorials are held on most firms and units. A journal club, open to all trainees, is held each week, and trainees can attend the day release lecture programme which caters for trainees throughout the Oxford Region. There is an annual neuro-sciences course, regular teaching throughout the year in psychopharmacology, and provision for secondment for instruction in neurology. Considerable emphasis is placed on psychotherapy training, and agreement has been reached amongst consultants to release trainees for training that extends across attachments. Supervised experience is provided in individual and group psychotherapy, together with theoretical instruction. Some trainees have been associated with research projects, and opportunities exist to develop an understanding of research methodology.

Progress reports

Regular evaluation by the Psychiatric Tutor of trainees' progress and of the training provided is an intrinsic part of the scheme. This is a sensitive task and one which is complicated by the vague and arbitary nature of the criteria for evaluation. Consultants submit a written report on the trainee's progress towards the end of each placement, emphasizing aspects needing further attention and noting how much of the report has been discussed with the trainee. All trainees are interviewed by a Tutor before they change appointments, and the contents of the report are discussed with them if appropriate and if the consultant concerned agrees. It is important to make clear that the purpose of written reports is primarily to clarify the individual's training needs. Trainees are allocated to one of the Tutors, and in addition to the regular review meetings are encouraged to see their tutor as often as necessary.

With regard to evaluation of training, as much information as possible is gathered from trainees and from discussions with consultants. Emphasis is placed on the range of experience provided, on the case load and on consultant supervision. Exploring these areas with colleagues is a delicate matter, especially when changes have to be recommended, but it is an essential part of the scheme.

Conclusions

Rotational training schemes have a number of inherent shortcomings. Organizational efficiency inevitably leads to a loss of flexibility, and the need for long-term planning of training sequences means that alterations are difficult to make. The question of how far service needs should be sacrificed to provide a good training scheme is fundamental. Frequent changes of registrar can disrupt the continuity of a firm's clinical work. On small units there may be an expectation by the longer-stay members of the team that the registrar will make little contribution to the ethos and development of the firm, and this may be detrimental to training. Certainly, rotation can limit the scope for learning through apprenticeship and reduce the consultants' interest in their juniors. Experience in Oxford, however, has shown that a large rotational scheme can form an excellent basis for general psychiatric training and enhance the standards of clinical service. The scheme has proved popular and has led to a high level of recruitment, allowing the selection of trainees who are seriously committed to the permanent practice of psychiatry.

THE EXETER SCHEME

By G. D. P. Wallen, Exe Vale Hospital, Exeter.

The problem

The group known as Exe Vale Hospital comprises three separate hospitals with a total of 1,066 beds serving a population of 600,000. There are 12 consultants in adult psychiatry, two in child and adolescent psychiatry and two in mental handicap based at the nearby Royal Western Counties Hospital. There are 17 junior trainees (nine SHOs and eight registrars), three senior registars and numerous clinical assistants, some of whom are trainees in all but name. Three SHO posts are reserved for the GP vocational training scheme. These doctors come for six months, occupying the same posts on each occasion. These posts have worked well here, and I would recommend having a nucleus of them provided that their special training needs are recognized. There are two part-time posts which rotate informally, leaving 12 formal rotating posts, five SHOs and seven registrars. These are likely to be increased to 14 in the near future.

The solution

The rotational scheme was designed to run for 3½ years to allow trainees to obtain the MRC Psych from

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scratch in one place. A little pressure increases incentive, but it is undesirable to produce anxiety about changing jobs just as the period of maximum study has arrived, particularly for overseas trainees. Six different rotational programmes were devised, with two trainees appointed to each. Most trainees enter as beginners, but the system allows people of varying experience to be appointed to a place in the programme appropriate to their needs. The last six months is a period of flexibility for those who are coming to the end of their training and allows some informal exchanges of post to gain experience omitted elsewhere.

The major branches of psychiatry are represented. Six months each are given to psychogeriatrics and child-adolescent psychiatry, the latter being combined with experience in mental handicap of one day per week. The specialties are neurology (one month attachment to DGH Department), psychology (one month attachment to Area Department based at Exe Vale), alcoholism (short attachment to Area Unit) and forensic psychiatry and administration, in which trainees gain experience by arrangement with their consultant, this being noted in their record books.

Each trainee on appointment receives a programme number and a personal, up to 42-month, timetable. All concerned are able to trace exactly where and with whom the trainee will be working until the 42nd month. Some weeks in advance of changes staff movement notices are circulated to remind teams that a trainee is leaving or joining and so that the personnel and finance departments can take the necessary administrative steps.

Trainees are attached to personal tutors throughout their stay, receive induction tutorials during their first six weeks from senior registrars and are interviewed by the Psychiatric Tutor who gives them a package containing useful information, reading lists, history taking schedules, etc, and a training record book containing details of the rotational training scheme, a curriculum vitae, and sections for recording experience gained or missed and examination results. The books can be presented for inspection when applying for subsequent posts.

Conclusions

The scheme has worked well, and I believe that it has contributed to a more ready acceptance of movement amongst medical staff. One complaint about staff rotation is lack of continuity, and though this has not been completely overcome all trainees do spend one period of at least 18 months in the same placement. All changes in individual teams overlap by at least three months, which is important for short-tenure posts such as child psychiatry. Both trainees do not move on the same day.

There is reasonable flexibility in the system, which probably strikes the right balance between rigidity and chaotic informality. Clinical assistant and other posts which rotate more slowly cushion any hiccoughs, the most common being failures to make new appointments. The smaller or short-tenure teams do need this cushion, and this is really a plea in favour of the experienced sub-consultant.

To say that the mechanics of this scheme are about right is not to say the same about the content. The period in mental handicap is inadequate and will be increased to three months whole-time when a new post is funded. Formal psychotherapy training is also deficient, and unless it is to be taught entirely by non-medical psychotherapists, as at present, will only improve with a change of central policy. If good training schemes and constant monitoring and administering as well as good teaching are genuinely thought to be desirable, those organizing them should be enthusiastically enabled to do so.

MEDICAL STUDENTS IN PSYCHIATRIC OUT-PATIENTS

By C. J. Salisbury and G. L. Harrison

A good doctor-patient relationship is central to the task of gathering information and providing treatment, especially in psychiatry. In a teaching hospital this relationship may be complicated by the presence of one or more medical students, watching in an uninvolved fashion, and possibly changing from visit to visit. If the students are seated to one side or even behind him, the patient may feel increasingly uncomfortable about exposing personal material in the absence of any visual feedback. A passive audience may be permissible in a general medical setting where information is less personal and amateur status is masked behind white uniforms. In psychiatry, however, the youthfulness and comparative immaturity of students may be heightened by casual dress and less formal clinics.

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