the columns

correspondence

Recruitment and selection into specialty training

Recruitment into specialty training in psychiatry has been a bruising and demoralising experience for both trainees, fearful of their employment opportunities, and their seniors, concerned for the future of specialty training in the UK (*Psychiatric Bulletin*, November 2007, **31**, 401–403).

We conducted an online survey of trainees in psychiatry in the North East rotation scheme. We obtained 56 responses (out of 150) from trainees of different grades. The majority (70%) reflected that the new single application for training programme through Modernising Medical Careers was unfair. Slightly more than half of the trainees (54%) would prefer structured interview as a method of selection, compared with knowledge-based tests (14%), work experience (14%), academic records (5%) and other means of selection, for example a mixture of the above (13%). Almost all of the trainees (95%) thought that Modernising Medical Careers was rushed and poorly communicated. The majority (82%) believed that specialty recruitment should be managed at a local basis at deaneries and more than half (54%) did not agree that the application process through a national IT system is a good technical solution.

The selection process into specialty training should be introduced gradually, with effective piloting and adequate resources. It is essential to support trainees who faced difficulties when the system came into effect last year.

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Pain and self-harm

Some older people with pain-related physical problems are at high risk of suicide (*Psychiatric Bulletin*, March 2008, **32**, 92–95). This is a neglected field of research.

We carried out a retrospective case note study of all individuals admitted to a general hospital after presenting to accident and emergency with self-harm and concurrent medical problems. Pain contributed to the episode of self-harm in 4% of cases. The mean age of these individuals was 46 years; 60% had experienced pain for over 6 months and 35% had a history of psychiatric disorder. They had a significantly higher suicidal intent associated with their acts of self-harm than those with non-painful physical problems (44% *v.* 30% respectively).

We recommended closer collaboration between general hospital services and local pain clinics for treating individuals with painful disorders who self-harm. Furthermore, we would encourage all clinicians to assess suicidal ideation and risk of self-harm when prescribing for this group. This is particularly important when considering prescribing analgesics or tricyclic antidepressants.

Further reading

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Supplementary prescribing by nurses

Nurse supplementary prescribing can improve patient care (*Psychiatric Bulletin*, April 2008, **32**, 136–139). It can provide greater patient choice and a better use of nurses' skills and knowledge (National Prescribing Centre, 2005). Although it is not clear where supplementary prescribing will be most useful, community settings (crisis team or memory clinics) seem the most appropriate places where supplementary prescriber can work independently. In these settings the nurse prescriber can, based on the clinical management plan, repeat prescriptions, adjust dose, switch and stop the medications (Gray *et al*, 2005).

Nurse prescribing in acute in-patient setting is more complex. New Ways of Working suggests that a consultant should focus on more complex cases where delegation of medical work would fall outside the competence of even the most highly trained nurse. The in-patient bed reduction and strengthening of community services by the crisis resolution and first-episode psychosis teams have ensured that only the individuals with the most complex illnesses are now admitted to acute psychiatric in-patient units. Surely their management should be a consultant's responsibility?

At the same time there is an increasing shift towards the functional model of working. The in-patient units are now more likely to have a dedicated consultant. They may limit the role of nurse supplementary prescriber, who may in turn increasingly take on the role of psychiatric trainees. This can lead to role confusion within clinical practice. There is also a risk that, in the in-patient units, supplementary prescribing may be used as a short cut to shore up differences caused by the reduction in junior doctor hours or even replace traditional roles of junior medical staff.

The complex shift patterns on the in-patient unit are another issue. In order to ensure a 24-hour nurse prescribing cover, a larger number of qualified nurses might need to be trained, and that may not be feasible.

As the number of supplementary prescribers increases and more sound research becomes available, it will become clearer which practice settings are most useful for supplementary prescribing.

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Nurse prescribing is a contentious issue (*Psychiatric Bulletin*, April 2008, **32**, 136–139). Although the benefits of a multidisciplinary approach to prescribing cannot be overstated, there are two potential problems. The main pitfall is the discrepancy between ability and expectation. Prescribing medication without knowledge of physiology and pharmacology is a recipe for disaster. Years of medical school training coupled with hands-on experience cannot be matched by training through prescribing courses.

The second equally important issue is related to psychiatric training for junior doctors. Nurses taking over such tasks as prescribing and mental state assessments will reduce the training opportunities for junior doctors who are already recovering from the double blow of the European Working Time Directive and a curtailed 6-year run-through system. There is a risk that their role might gradually be restricted to chasing blood tests results, carrying out physical examinations and dictating summaries. In the course of time, a cohort of 'trained' psychiatrists may emerge with potentially less hands-on experience. Expecting them to oversee risk management might be a little unreasonable.

Declaration of interest

A.H. is a run-through trainee at ST3 level.

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Making the most out of the Gold Guide

While some of the trainees have not yet completely recovered from the stormy entry into the run-through system, others are about to face their annual review of competence progression. The Postgraduate Medical Education Training Board has set out clearly the operation of the competence-based specialty training in the UK. Its offshoot product, the 'Gold Guide' (Modernising Medical Careers, 2007), seems to be the Bible to follow in the new era of training. However, several months into the system this 'golden guidance' has yet to become popular among trainees. Of particular interest is the section which explains three integrated components of the process, the 'three As' – appraisal, assessment and annual planning.

The appraisal should be a continuous process happening at regular intervals. In my opinion, it is the crucial part of the review. The importance of educational supervision was also highlighted by Day & Brown (2000) and Sembhi & Livingstone (2000). The assessment seeks clear evidence and proof of achievement in both performance (workplace-based assessments) and experience (log book, audit and research). Based on this, the trainees' future needs can be identified (annual planning).

The annual review of competence progression appears a well-considered plan. However, there are some inherent difficulties in its implementation, particularly in psychiatry. For the specialty trainee year 4, identifying educational supervisor other than a clinical one has been an issue. Research sessions and special interest sessions have not been considered in the review, probably because traditionally they have not been part of other specialties' training curriculum. Therefore, for example, getting a report from research supervisor for the review is not feasible. Some centres have only 4-month training posts for specialty trainees years 1–3, too short for any effective appraisal process. The most burdensome aspect at the moment seems to be nominating people and getting feedback from the multidisciplinary team through the online system. Trainees can easily find themselves frantically running around to get the forms filled.

Notwithstanding, this system is a better way of testing and developing competence progression. It has given us the opportunity to be reflective in our learning experience and it has managed to merge clinical and educational supervision in the best possible way. It is bound to have some initial hiccups, but the best way to deal with them is to take an optimistic approach, familiarise with the Gold Guide and get on with the tasks.

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Recruiting psychiatrists – the Singapore experience

In view of the current shortage of psychiatrists worldwide, it is important to understand the impact of an undergraduate posting in psychiatry on medical students (Brockington & Mumford, 2002). Earlier studies showed that postings in psychiatry can positively influence students' attitudes and knowledge about the specialty. We conducted a pilot study to examine the influence of a posting in psychiatry on the career plans of medical students (Holmes-Peterson *et al*, 2007; Cutler *et al*, 2006). Third-year students (n=72) in Singapore filled out a 30-item self-report survey after their 4-week clinical posting in psychiatry. The questionnaire examined the preferred specialty before entering medical school, the change in attitude towards psychiatry after the posting, the consideration of psychiatry as a career after the posting and the reasons for that.

The majority of students indicated an improvement in their attitude towards psychiatry, in tune with earlier studies worldwide. About 39% had a preferred specialty before the psychiatry posting. For male students it was surgery, followed by orthopaedic surgery, and for female students, obstetrics and gynaecology, followed by paediatrics and surgery. Only one student preferred psychiatry before the posting. After the posting, 68% wanted to consider a career in psychiatry – 20% of this group had indicated a specific non-psychiatric career choice earlier on. Experience during the posting was the most important factor for changing their career plans (this was regardless of the students' gender).

The study showed that posting in psychiatry can have a direct influence on (re)consideration of psychiatry as a career option in undergraduates. Although Eagles *et al* (2007) reported that most definitive career choices will be made during the (early) postgraduate years, our findings are encouraging and more research in this area could be beneficial to improving the recruitment of future doctors into psychiatry.

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