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.

https://doi.org/10.1192/S0140078900005447 Published online by Cambridge University Press

We wondered whether patients felt significantly inhibited by medical students, and if so whether they would prefer alternative teaching methods, such as video or a one-way screen. Several authors have commented on the lack of communication between doctors and patients, and various aspects of this also interested us: were patients expecting to have students present; did they know they could object; and were they given the opportunity at interview to do so?

Patients and methods

In psychiatric out-patient clinics in Bristol, medical students are present in groups of two or three, seated to one side or behind the doctor. Interviews are usually observed passively, although in one clinic a student may be asked to see a patient beforehand.

One hundred patients from clinics in two Bristol hospitals (three different consultants) were asked to complete a ten-part questionnaire while waiting for their consultation. Although the impersonal nature of a written questionnaire has obvious weaknesses, it may encourage an honest expression of attitudes. The questions used are given in full with the results. All new psychiatric out-patients in Bristol are sent a form with their appointment stating that they may see students and that if they wish they may object. Questions 5–7 relate to this.

Results

Out of the original 100 patients, two were unable to answer the questionnaire because of poor sight, and four returned it uncompleted. Questions 1 and 2 showed that the remaining 94 patients sub-divided into three groups:

(a) Patients on their first visit to a psychiatric out-patient clinic (35 per cent of total).

(b) Follow-up patients who had not had students present at any previous visits (21 per cent total).

(c) Follow-up patients who had previous experience of students (44 per cent).

All figures given are the percentage of the total number of patients in that sub-group, unless otherwise specified.

Question 3 Would you prefer to go to an out-patient clinic in:	All Patients	(a)	(b)	(c)
(a) A teaching hospital, where students may be present	15	21	5	15
(b) A non-teaching hospital, where students will not be present	22	30	15	19
(c) No preference	63	49	80	66

Question 4 In a teaching hospital, where students may be present, which would you prefer:	All Patients	(a)	(b)	(c)
(a) To have students in the consulting room with the doctor, as happens at present	45	39	40	51
(b) To be seen by the doctor alone, while being recorded on TV for students to watch the film later	12	15	—	14
(c) To have students in an adjacent room where they could see you, but you could not see them (through a 'one-way' screen)	10	12	10	7
(d) No preference	24	18	30	26
(e) I would object to students being present or seeing my consultation in any way	7	9	20	—
(No answer)	2	7	—	2
Question 5 Were you expecting there to be medical students with the doctor today?				
(a) Yes	28	27	—	41
(b) No	47	46	80	32
(c) Don't know	25	27	20	27
Question 6 If so, approximately how many?	(Percentage of those who answered yes above)			
(a) One	37	24	80	38
(b) Two to four	53	59	—	59
(c) Five to ten	6	6	20	3

	All Patients	(a)	(b)	(c)
(d) Eleven to twenty	—	—	—	—
(e) More than twenty	—	—	—	—
(No answer)	4	11	—	—
Question 7 Did you know that you could ask not to have students present, if you very much objected?				
(a) Yes	59	64	30	71
(b) No	37	27	70	29
(No answer)	4	9	—	—

The following two questions are only applicable to follow-up patients who have seen students on previous visits

Question 8 On your last visit when students were present, did you feel you were given the opportunity to refuse to see medical students?	percentage of (c)
(a) Yes	69
(b) No	31

https://doi.org/10.1192/S0140078900005447 Published online by Cambridge University Press

Question 9

Were there things relating to your problem that you did not feel able to tell the doctor?	Percentage of those answering 'yes'			
	All Patients	(a)	(b)	(c)
(a) Yes, because I did not feel at ease with the doctor	6			17
(b) Yes, because I did not feel at ease because the students were present	14			38
(c) Yes, because I did not feel that the doctor would be interested, or that it would be relevant	10			28
(d) Yes, because I felt it was personal, and not the business of anyone else	6			17
(e) No, I felt able to tell the doctor everything about my problem, even though the students were present	55			—
(No answer)	9			

Finally, patients were asked to make general comments about medical students, and 38 per cent of the patients did so. Half of the patients who made comments felt that students had to be taught, and therefore did not mind their presence. Sixteen per cent said they were sometimes made uneasy by students, depending on what they were discussing. One patient wanted to refuse, but felt the doctor would be antagonistic towards him if he did. Another patient feared that a student would break his confidence, and another claimed to have heard students discussing patients over coffee, accompanied by 'riotous' laughter.

Comments

Although over a third of the follow-up patients felt they had been unable to explain their problem fully, only 38 per cent of these attributed this to the presence of students. This represents only 14 per cent of all patients with experience of students. It would appear, therefore, that for most patients they are not a serious inhibition to the interview. Michaels and Sevitt (1978), in a study on the first psychiatric interview, found that many patients were inhibited in the interview for various reasons unconnected with students. The present teaching method, with two or three students sitting in the consulting room with the doctor seems satisfactory, both in terms of practicality and patient acceptance.

Patients are not, however, very well informed with regard to medical students. Forty-six per cent of new patients did not realize that students might be present at their interview, and 9 per cent would find this objectionable. It is difficult to know how to rectify this, as information is already sent out to every new patient. Skuse (1975) has shown that patients who are informed about what to expect in psychiatric out-patients are twice as likely to attend subsequently as those who are not. The information in Skuse's study, however, was personally conveyed, and the apparent ignorance of so high a proportion of new patients in the present study confirms the limited value of written communication. We must agree with Michaels and Sevitt (1978) when they recommend that general practitioners should spend more time explaining what to expect in psychiatric out-patients at the time of referral. This problem of lack of communication between doctor and patients is highlighted in Reynolds' (1978) study of surgical patients at another Bristol hospital.

Thirty-seven per cent of patients in our study did not know that they could object to the presence of students. This is a controversial issue, and the 'right' of patients to refuse to see students in a teaching hospital is not always supported by medical staff. Although it is hospital policy in Bristol to tell patients that they may refuse, 31 per cent did not feel they were offered the opportunity at interview. This study suggests that overall only 7 per cent of patients would object to students. A personal reminder would possibly do much to clear up patients' expectations, with little actual loss of teaching material.

Acknowledgements

We would like to thank the psychiatric clinic receptionists for help in distributing questionnaires, and Dr M. G. Barker, Consultant Psychiatrist, for his advice about the original project.

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https://doi.org/10.1192/S0140078900005447 Published online by Cambridge University Press