Correspondence

Postgraduate training in psychiatry

Sir: As a former trainee in psychiatry in The Netherlands I would like to make the following comments on the article by Hall & Robertson (*Psychiatric Bulletin*, August 1996, **20**, 482–484). After receiving the Certificate of Completion of Specialist Training (CCST) child psychiatrists spend a further year in their speciality for which they receive an additional certificate, provided they have spent a 12 month period of training in child psychiatry during their rotation. Otherwise they need an additional two years in child psychiatry to obtain this certificate (Centraal College, 1994).

Hall & Robertson report that trainees in psychiatry are shielded from an excessive clinical work-load. This is mainly true for trainees in University Hospitals. However, of the 20 psychiatric hospitals in The Netherlands which have training approval only eight are University Hospitals. This means that the majority of trainees do not enjoy this privilege and, in fact, they often have a clinical work-load twice the size of their academic counterparts.

It is true that the MRCPsych is being recognised as a postgraduate qualification in The Netherlands. However, this does not mean that a person having acquired this qualification is automatically eligible for a CCST and specialist status in The Netherlands. It requires the member to work for a period of time (on average a year) under the supervision of a Head of Department (or teaching director) after which the Head of Department can recommend specialist eligibility to the Central College of Medical Specialists (Centraal College, 1982).

Furthermore, in 1991 there were three members of the College working in The Netherlands (Royal College of Psychiatrists, 1991), while there are currently 12 members doing so (personal communication, Registration Officer, Royal College of Psychiatrists). So, although there is the theoretical possibility of "progressing to consultant in the fast lane", the reality is that the total number of Dutch trainees obtaining the MRCPsych remains negligible.

CENTRAAL COLLEGE (1982) Inschrijving in specialistenregister van in het buitenland opgeleide medische specialisten. *Medisch Contact*, **30**, 151–153.

— (1994) Opleidingseisen psychiatrie. *Medisch Contact*, **8**, 269–279.

ROYAL COLLEGE OF PSYCHIATRISTS (1991) *Membership List*. Dorchester: Dorset Press.

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Sir: There has been recent correspondence in your Journal about the effects of the Calman changes on psychiatric training (Caldicott, 1996*a*) and in particular the compatibility of our training with that in other EU countries. I have concerns that the way Calman has been implemented in psychiatry will disadvantage the future recruitment of doctors into psychiatry and have almost no effect on standardising our training with the rest of Europe.

It is said that "Psychiatric training in Britain and Ireland will take six to seven years" (Caldicott, 1996*b*). This is not the case. In order to sit the Part II of the MRCPsych examination one must have completed three years of training and must sit it while in a training job, therefore having done at least 31 2 years before they will be ready to apply for a specialist registrar job. I would wholeheartedly support the views of Cervilla & Warner (1996) that to obtain accreditation in only one of the four psychiatric specialities (which are unrecognised in either the EU or Commonwealth countries) would be seen as a disadvantageous career move. Hence a majority of trainees are likely to spend four years at the senior registrar grade.

British training at $7\frac{1}{2}$ years (minimum) compares with a Portuguese, Greek or Belgian training of 4 years (in Belgium with no formal examination). Any British medical graduate who wished to pursue a career in psychiatry would be well advised to undertake their training in one of these European countries and return fully accredited for Consultant work.

CALDICOTT, F. (1996*a*) Certificate of Completion of Specialist Training (CCST): implications for higher training in psychiatry. *Psychiatric Bulletin*, **20**, 372–337.

— (1996*b*) Training in psychiatry in Europe. *Advances in Psychiatric Treatment*, **2**, 141–142.

CERVILLA, J. J. & WARNER, J. P. (1996) Certificate of Completion of Specialist Training (CCST): implications for higher training in psychiatry. *Psychiatric Bulletin*, **20** 372.

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Fellowships of Royal Colleges

Sir: In the September issue of the *Bulletin*, Dr Moliver questions the role of Fellowships in Royal Colleges and suggests that they could be abolished (*Psychiatric Bulletin*, **20**, 565). An alternative approach is to develop Fellowship as a high

professional achievement in their speciality of which members of a Royal College can be proud.

In 1989 the Royal College of General Practitioners (RCGP) introduced Fellowship by Assessment which is a patient-centred assessment, based on a visit to the workplace of the applicant. The RCGP (1995) has published a list of essential criteria, each of which must be achieved, and each one of which is patient based. The assessment visit is undertaken by three established Fellows, increasingly themselves Fellows by Assessment, and doctors achieving this standard have reported gaining very considerable personal and professional satisfaction from doing it (Price, 1995).

This certainly prevents the Fellowship becoming a "self-perpetuating oligarchy which will tend to exclude those who have a low profile on the national regional scene but may still be doing good work". The RCGP system is open to every member of five years' standing and is based entirely on good work in the locality. Regional and national service is irrelevant. It is currently available as an alternative route to the RCGP Fellowship and Dr Moliver and other readers may find it of interest.

PRICE, A. (1995) FBA the Cornish way – a group experience. In *Fellowship by Assessment. Occasional Paper 50*. 2nd edition. London: RCGP.

ROYAL COLLEGE OF GENERAL PRACTITIONERS (1995) *Fellowship by Assessment. Occasional Paper 50*. London: RCGP.

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Non-conversion of Section 5(2)

Sir: The Commission's report (Mental Health Act Commission, 1987) expressed concern about the use of Section 5(2) as an independent power of short-term detention for 72 hours rather than as a measure to provide authority to detain while an assessment for compulsory admission may be made. Incorrect use of Section 5(2) may result in the hospital being sued for damages, for false imprisonment and for negligence. Three published studies (Mason & Turner, 1994; Joyce *et al*, 1991; Pourgourides *et al*, 1992) raised questions about the appropriate use of Section 5(2).

In an extensive review of a much larger sample size, all applications of Section 5(2) of the Mental Health Act 1983 in North Cheshire between 1985–1995 were reviewed to examine general trends in its use and outcome. Between 1985–1995, there were 20601 admissions to Winwick Hospital, which serves the whole of North Cheshire, including 898 Section 5(2) applications. The conversion rate of Section 5(2) to other sections of MHA in this review was 57%, similar to that reported by Mason & Turner, 55% (1994); Pourgourides *et al*, 52% (1992); and Joyce *et al*, 48% (1991).

In 20% of cases, an application for Section 2 was made at the same time as Section 5(2). Indications for Section 5/2 included aggressive behaviour (16%), deliberate self-harm and suicidal threats (34%), and acute psychosis (44%). The low conversion rate was probably due to the fact that most patients were involved in acute transient behavioural disturbance. Low conversion rate of Section 5(2) to other sections of MHA should not be taken as an indicator of the incorrect use of the order.

JOYCE, J., MORRIS, M. & PALIA, S. S. (1991) Section 5(2) audit. *Psychiatric Bulletin*, **15**, 224.

MASON, P. & TURNER R. (1994) Audit of the use of doctors' holding power under section 5(2) of the MHA 1983. *Health Trends*, **26**, 44–46.

MENTAL HEALTH ACT COMMISSION (1987) *2nd Biennial report 1985–1987*. London: HMSO.

POURGOURIDES, C., PRASHER, V. P. & OYEBODE, F. (1992) Use of Section 5(2) in clinical practice. *Psychiatric Bulletin*, **16**, 14–16.

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The Geoffrey Knight Unit has survived

Sir: This Unit has provided a significantly decreased level of service during the past year. I can now inform readers that we remain available for referrals, and the Unit has now moved from the Brook General Hospital to the Maudsley Hospital, London.

The first problem was that the Greenwich NHS Trust unilaterally reduced our beds from eight to four. This saved money and, with some other savings, it was possible to buy an MR scanner. Unfortunately, this was second-hand and never functioned before it became obsolete. Then, at the end of 1994, we were told that radio-yttrium, which we used to produce the lesion for our stereotactic subcaudate tractotomy operation (Bridges *et al*, 1994), could no longer be supplied because we were the only users. There was a delay for modifications and we are now using radio-frequency to produce the lesion. While psychosurgery was halted, we continued to admit patients for trials of high dose and combined antidepressants (Bridges *et al*, 1995) which, our clinical experience has shown, has reduced the need for psychosurgery in recent years.

The situation at present is that out-patients are seen at the Maudsley Hospital, we have in-patients at the Bethlem Royal Hospital and beds are available to us on the neurosurgery wards at King's College Hospital.