Career progression – use of the trainee logbook

As senior house officer trainees approach the end of their training and prepare to apply for higher specialist training, they become more concerned with the ‘publications’ section on the job application forms for specialist registrars. By then they have either already published something in a journal or are desperately trying to do so. Recently, with the increased competition for higher specialist training posts, it has become an unwritten rule that one is unlikely to get short listed if the ‘publications’ section is left blank. The consensus is that trainees at senior house officer level are competing in terms of how many published letters or articles they have written/co-written.

We do not question the value of published work in the selection process, nor do we doubt its relevance to career progression. However, we wonder if the field of vision has become unhelpfully narrow. We wonder whether, in parallel with the ongoing changes in the training of psychiatrists, the assessment of suitability for career progression should shift from cross-sectional to longitudinal assessments of trainees’ performance. An excellent tool for assessment, which trainers and trainees have long used, is the College’s trainee’s logbook (http://www.rcpsych.ac.uk/PDF/LogBook.pdf). It includes almost all that is essential for a comprehensive evaluation of a trainee. The two sections of training goals and supervisors’ feedback are particularly useful for acquiring an overall view of career development.

Psychiatric training in the UK is constantly evolving. In August 2007, the Postgraduate Medical Education and Training Board will supersede the Specialist Training Authority and the Joint Committee on Postgraduate Training for General Practice. It is hoped that the selection of trainees for higher specialist training will involve a more-balanced structured assessment rather than a tick-box format. However, the assimilation of the current trainees into the new system is yet to be clarified. Advertising for specialist registrar posts will cease after August 2007. Guidelines for their point of entry into the new training scheme are not very specific. One worry is that the unfortunate ones will be forced to settle for non-training career grade posts. A way of allaying such anxiety about job prospects in higher training is to allow the use of relevant documentation compiled by trainees throughout their training. The logbook is a very useful tool for writing and updating CVs and for the purpose of interviews. We believe it has greater potential as a genuine record of experience and a reflection of the aptitude and suitability of a trainee for a job.

*Ahmed Alwazeer  Senior House Officer in Psychiatry, St Michael’s Hospital, South Warwickshire PCT, Warwick CV34 5BW email: alwaeezer@doctors.org.uk,

Waleed Ahmed  Senior House Officer in Psychiatry, St Michael’s Hospital, South Warwickshire PCT

Impact of a waiting list initiative of a child and family out-patient mental health team

This initiative sought to reduce the waiting list and to improve the triaging process of an out-patient multidisciplinary team based at the Royal Hospital for Sick Children in Edinburgh. The team consists of 6.5 whole-time equivalent clinicians and receives 250 referrals of children aged under 14 each year. All referrals (n=66) on the waiting list were offered an initial assessment during a 2-week period in July 2005. Interdisciplinary pairs were formed and each pair was assigned a clinic session comprising two 1-h assessments. A weekly meeting was held to discuss all cases and to prioritise and allocate according to need and the skills required to manage the problems.

Sixty-six patients were offered appointments and 46 of these attended. Thirty-seven patients (56%) were allocated to clinicians for further management, 21 (32%) cases were closed and 8 patients (12%) remained on the waiting list for further management. After 6 months, there were 33 on the waiting list, with an average waiting time of 5 weeks, which was down from 4.5 months.

The initiative was an effective way of assessing and allocating patients in a more appropriate and timely fashion, and resulted in a considerable improvement in the service offered. It also resulted in the establishment of regular ‘initial assessment clinics’. The experience had the effect of motivating the team, encouraging the sharing of ideas and generating action.

Anna Beaglehole  Senior House Officer in Psychiatry, Fiona Forbes  Consultant in Child and Adolescent Psychiatry, Child and Family Mental Health Service, Royal Hospital for Sick Children, Edinburgh TILL, email: Fiona.Forbes@pct.scot.nhs.uk

Research day for specialist registrars

Około & Ogundipe (Psychiatric Bulletin, July 2006, 30, 275–277) have raised important issues regarding the research day for specialist registrars. Although it has been considered appropriate for the research day to be used for high-quality audits, teaching/training and postgraduate courses in addition to field research, our deanery expects concrete proof of publications and/or research funding, as part of the Record of In-Training Assessment. We constantly find ourselves having to explain the gap between achievements and expectations. Some trainees are clearly not interested in research and it is not ideal to force disinterested people to undertake research projects. For trainees that are interested in research, the opportunities are not readily available. Guidance and advice are poor, unless trainees are able to tap into an ongoing project. The alternative is for the trainee to spend all their training trying to understand the system, which has been my experience.

More thought needs to go into the use of the research day and if trainees are expected to produce results they need the resources to enable them to do this. The programme director needs to be involved in tailoring the research day to the interests of the individual trainee.

I hope that the Postgraduate Medical Education and Training Board takes this into consideration before the new system
Changning role of the junior psychiatrist – implications for training

Imagine the daily life of the junior psychiatrist in the not too distant past: clerking of new admissions to the ward day or night; physical examinations and routine phlebotomy; providing a service to the general hospital for psychiatric emergencies, including overdose assessments; reviewing the patients’ mental state in the clinic and prescribing medication; responding to requests from nursing staff manning the wards when all others are sleeping.

How the life of the junior doctor has changed! The first to go was routine phlebotomy, closely followed by a variety of other tasks which are now performed by non-medical professionals whose roles are ever increasing. As highlighted by Woodall et al (Psychiatric Bulletin June 2006, 30, 220–222), liaison assessments are increasingly being carried out by specialist nursing staff, with an inevitable effect upon the experience gained by senior house officers. The driving force behind this remains unclear. The European Working Time Directive has been implicated in these changes, but the other more cynical view is that doctors’ time is more costly than that of nursing and auxiliary staff.

With nursing staff taking on prescribing, triaging of emergency calls and assessment in all settings and at all hours, what are the doctors left with? How ironic that junior doctors who no longer perform these roles as part of their training will very soon, with the introduction of the run-through grades, be supervising the practice of these highly experienced non-medical professionals.

*Louise Cooke Senior House Officer in Child Psychiatry, 4th Floor, Bridgewater House, Blackpole Road, Worcester WR4 9GG, email: louise.cooke@yahoo.com.

Louisa James Specialist Registrar in General Adult Psychiatry, Crisis Resolution and Home Treatment, Bridgewater House, Worcester

Woodall et al (Psychiatric Bulletin, June 2006, 30, 220–222) describe how the introduction of nurse-led liaison services has left senior house officers (SHOs) with little to do on call. Senior house officers are left with routine ward work while nurses become skilled at emergency psychiatric assessment. The original purpose of the changes was to leave some of the simpler tasks to nurses, freeing the SHOs to carry out work traditionally considered to require a doctor. The pendulum has now swung too far, with specialist nurses taking over increasing amounts of doctors’ work. These changes resulted from the implementation of the European Working Time Directive after vociferous protest by earlier generations of SHOs over poor pay and excessive working hours. The government, for financial reasons, was happy to heed these protests and has implemented these changes at a time when the length of postgraduate training is being reduced by the Modernising Medical Careers initiative.

The remedies proposed by Woodall et al are primarily bureaucratic and will take valuable time to implement. A more prompt and practical remedy would be for SHOs to return to where they belong, in the acute clinical front line. In the words of their specialist nursing colleagues, evaluation of the efforts of both, using audit systems already in place, would provide a useful opportunity to test the fundamental and as yet unanswerable question that lies behind the current changes: do doctors have more to offer than nurses in the assessment and management of acute psychiatric emergencies?

Chloë Beale East London and the City Mental Health Trust, Homerton Hospital, London E9 6SR, email: clioxe.beale@elcmht.nhs.uk

Woodall et al (Psychiatric Bulletin, June 2006, 30, 220–222) highlight the potentially adverse effects on the clinical experience of psychiatric trainees of increased reliance on liaison nurses to conduct emergency psychiatric assessment. As members of the liaison teams in the hospital in Wrexham where the study was conducted, we would like to respond. Liaison psychiatry, in particular the assessment of patients after self-harm, offers excellent opportunities for trainees to develop a range of clinical skills, including rapport in difficult circumstances, comprehensive history-taking and mental state examination, case formulation, risk assessment, negotiating a management plan with the patient and communicating effectively with all parties. We wholeheartedly support the development of the role of liaison nurses because it increases capacity and improves service delivery. However, we are concerned about the effect that this might have on the clinical experience of psychiatric trainees. Hence for some time we have invited trainees to voluntarily undertake psychosocial assessments jointly with liaison nurses. However, the uptake of this offer has been variable and this latest study has underlined the need for a new approach.

With the consensus of consultant colleagues, all junior psychiatrists will now be required to complete ten joint psychosocial assessments every 6 months in addition to their on-call work. They will observe the first few assessments while the liaison nurse takes the lead, and then take the lead on the remaining assessments. Trainees will also continue to

is established, so that this whole process represents good value for money and effort.

Indira Vinjamuri Specialist Registrar in Adult Mental Illness, address supplied, email: vinjamuriindira@nhs.net