The medical officers' scores on the clinical examination ranged from 7-13. The mean ± s.d. post-training score was 11.2 ± 1.6. Twenty-six (68%) of the doctors scored above 75%. When this group was compared with the remaining 12 doctors, no significant differences emerged. Qualitative evaluation of the responses revealed that, out of 456 possible responses, there were no major errors and 16 (35%) minor errors. In another 22 instances (4.8%) no answers were written. These response categories mainly included management of side effects, non-pharmacological aspects of management, duration of treatment and the specific advice that was to be provided about illness and treatment. The most commonly noticed error was an inability to distinguish between anxiety neurosis and depressive neurosis.

Comment
Clinical examination as a method of assessment would seem to have face value as the most appropriate method of assessing clinical skills. However certain of the limitations of clinical examination have to be overcome to make it more valid. The first problem is the frequently observed heterogeneity of patient characteristics. Patients often differ with respect to their manifest symptomatology, cooperativeness, and ability to convey the required information in the most appropriate manner to arrive at a diagnosis. Since these are likely to influence trainees’ performance, it is necessary for the assessor to ensure adequate homogeneity of the patients. This was ensured in the present investigation by prior screening of patients. The second problem pertains to the rating of trainees’ performance in an objective manner. To ensure this, a structured response sheet was used.

The results of the present investigation suggest that primary care physicians can effectively recognise and manage mental health problems. Clinical errors are infrequent and are of a minor nature. However, it is not implied that more serious errors would never occur in the doctors’ practice since there will often be difficult clinical situations. The doctors might refer such problems to a specialist. Alternatively they might carefully monitor the patient's progress and revise the diagnosis and treatment. Finally there is the remote possibility that a major error would go unrecognised. This highlights the need for an evaluation of the doctors’ diagnostic and therapeutic practices during their actual practice following training.

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Extending management training for senior registrars

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It is recognised that the consultants of the future will have a greater management role than those of the past. The Griffiths report (1983) regarded doctors as ‘natural managers’, although this has been challenged by some authors. They suggest that medical training, with its emphasis on the individual case and rapid
decision-making (Higgins, 1989), leads to a very
different perspective from the manager considering
the often competing long-term needs of many indi-
viduals.

It was recognised by Griffiths himself that manage-
ment should be an integral part of training. The NHS
Training Authority (1986) suggested that manage-
ment training may be divided into three areas:

(a) helping doctors to practice their clinical skills
more effectively
(b) increasing the effectiveness of doctors' con-
tributions to management decisions
(c) enabling clinicians to manage their depart-
ment or service more effectively.

It was subsequently suggested (NHS Training
Authority, 1989) that although the first area should be
taught locally from the earliest years of training (e.g.
by audit, cost awareness), the latter areas should be
taught after completion of postgraduate examina-
tions. It was recommended that such training
should consist of involvement with local manage-
ment, supplemented by selected formal courses.
Ideally, both personnel and resource management
issues will be covered. Personnel management
includes skills such as leadership, team-building and
motivation, the management of conflict and effect-
ive recruitment (NHS Training Authority, 1986).
Resource management may include training in
budget holding and information technology.

A variety of courses have been developed for
senior registrars, both at regional and national level,
e.g. by the Kings Fund. Such courses are normally
short, lasting a week or less. More advanced courses
are offered, usually leading to a management qualifi-
cation (either from the Institute of Health Services
Management or the degree of MBA) and lasting
several years. At present few intermediate options
are available, although the Welsh model (Smith, G. J.
et al, 1986) merits further consideration. A planned
programme of management development takes place
over three years; after 15 half-day visits to relevant
departments and units in the first year, the trainees
attend a one-week residential management course in
their second year, followed by a more advanced
course a year later. At this time, teaching in manage-
ment skills, including effective chairmanship and
committee skills, takes place. However, the general
lack of such courses would appear to mean that
senior registrars' management skills are unlikely to
be maximised.

It is recognised that courses must be supplemented
by involvement in local management. For most
trainees, this will consist of attendance at Medical
Staff Committees and Divisions. Some trainees may
also have the opportunity to attend planning meet-
ings, particularly in specialities dealing with long-
term care, e.g. psychogeriatrics and rehabilitation.

Apart from such meetings, trainees have limited
contact with managers.

Having attended a short management course and
had experience of local medical advisory committees,
I wished to extend my management experience. The
NHS Training Authority (1986) suggested the use
of management 'apprenticeships' and I therefore
arranged an experimental one-week attachment with
a local Unit General Manager (UGM). I received a
high degree of co-operation, both from the UGM
and from the District Health Authority managers,
which enabled me to observe the complete workload
of that week. During the 48 hour week worked
(range: 8.75–10.6 hours/day), the time spent in
various activities was noted.

The proportion of time (shown in brackets) a
UGM devotes to activities varies from week to week,
and one week was insufficient to observe all the
activities undertaken. In the week's attachment, half
the time was divided between dealing with corre-
spodence (24%) and meetings at the District Health
Authority (23%). These meetings covered budget
setting, personnel management, service planning and
evaluation of staff development courses, and were
supplemented by interviews with individual district
officers (6%). Time spent in the local unit was divided
between meetings with managers, of broadly similar
content to those at the District Health Authority, but
focused on local issues (14%) and interviews with
individual staff (18%). Unit General Managers from
the region met to discuss the White Paper (4%); the
remainder of the time was spent in travel (8%) and
lunch (3%).

During the week, it became clear that doctors'
individual relationships with patients, and their
commitment to their welfare, is reflected in their
behaviour in medical advisory machinery meetings.
The managers of the District Health Authority were
more able to view issues dispassionately. Their
committee skills, coupled with effective chairman-
ship, enabled their meetings to be more productive in
terms of material covered and decisions reached than
medical advisory meetings often appear to be.

The management attachment allowed local issues
to be examined from a variety of perspectives. Obser-
vation of the functions and organisation of District
Health Authority managers enabled deeper under-
standing of material presented in theoretical man-
agement courses. The extent of local training courses
available to managers, but not widely advertised to
doctors, e.g. in leadership and team motivation,
revealed the potential for further extension of
management training.

It was also clear that the knowledge base of a man-
ger is in many ways as broad as that of a doctor.
However, the areas of expertise of doctors and man-
gagers seldom overlap, which results in potential for
mutual underestimation.
The management role of consultants is continually increasing; if they are to make effective contributions to management decisions and management of services, it is essential that they are adequately prepared. Management training should not be an optional, but an 'integral part of training' (Smith et al, 1986). There is a need both for theoretical management education throughout higher training (as in the Welsh model), and for practical management experience. A short attachment to a Unit General Manager would be a useful addition to every senior registrar's training programme.

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Trainees’ forum

Career progression in psychiatry: perceptions and realities

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The guidelines on criteria necessary for promotion to senior registrar grade in psychiatry may be found in The Handbook for Inceptors and Trainees 1987. The criteria are essentially those in the 1980 edition, namely the need for possession of MRCPsych status and completion of at least three years general professional training approved by the College. Yet it is undeniable that in recent years eligible candidates have experienced much more difficulty in achieving appointment as a senior registrar. Indeed Holden (1988) comments that “dedicated clinical service and the qualification of MRCPsych is insufficient to guarantee a registrar success in his or her application for a senior registrar post”. In the increasingly competitive job market research experience, possession of publications, and management training have become valuable assets for prospective candidates. Our concern at the lack of pertinent career guidance for trainee psychiatrists prompted us to look at trainees’ perceptions of requirements and at the provisions which exist in their training to enhance their career prospects.
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