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Correspondence

A hospital hostel saved from closure

DEAR SIRS

In view of recent concern about the plight of the long-term mentally ill and the future of continuing care beds, your readers may be interested to hear how a hospital hostel has been saved from closure.

When the Health and Community Care Act became law, our District Health Authority was required to make revenue cuts to achieve "a level playing field". The management of the General Health Services Unit, of which our adult psychiatry service forms part, put forward a package which included among other things the closure of a geriatric ward for continuing care and of The Lodge, the latter being a ward in a house in a converted property on the edge of a hospital site, serving six new long-stay patients. These six places are the only long-stay beds in our district where vigorous community care policies have for many years been successful in resettling such patients and supporting them in the community. Were The Lodge to close, its residents would have to return to an acute ward on the District General Hospital site.

The Division of Psychiatry argued that, not withstanding the proposed transfer of lead responsibility for care of patients in the community to social services, a small number of patients would always need the security and professional expertise which is only available in directly managed NHS places, a need which is acknowledged in the White Paper *Caring for People* where it is described as "Asylum". We were tempted to preserve our hostel ward by converting it to a nursing home and devolving it to a quasi independent organisation so that patients could receive welfare benefits, but thought we should fight for the principle of maintaining at least a minimum number of continuing care NHS beds. In this, we were supported by the local Community Health Council and by the West Midlands Regional Advisory Team on psychiatric rehabilitation.

The District's decision to close The Lodge was upheld by the Regional Health Authority but, after considerable delay, was overturned by the Department of Health on the grounds that appropriate replacement provision had not yet been developed. Such replacement provision was not specified but the preservation of the existing hostel embodies the principle that at least some such provision may be the existence of directly managed NHS places. Recent communications from the Department commending the work of hospital hostels would appear to support this.

Our experiences suggest that it may well be worth resisting attempts at closure by local management who, while financially hard pressed, often have imperfect understanding of the needs of chronic psychiatric patients. The attitude of the Department now seems more supportive.

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Peer support for trainees

DEAR SIRS

Trainees in psychiatry are under numerous pressures. They have to cope with a wide spectrum of difficult illnesses, about which all too often very little is known, and towards which treatment strategies are extremely diverse. It is very seldom the case in psychiatry that patients can be readily slotted into a diagnostic category and administered a standard package of care. Thus, the relative certainty which pertains by-and-large in other areas of medical practice is not the case in our specialty. This makes the transition from medical schools (where undergraduates are part of an often cosily structured patriarchy) to the uncertainties of psychiatric practice all the more difficult.

The threat of violence from psychiatric patients is omnipresent, and often training in this area is inadequate, and appropriate support lacking. Trainees also have moral and practical difficulty with the management and treatment of patients who lack "insight" and have to be treated against their will.

Furthermore, trainees are constantly aware of the impending day of reckoning with the MRCPsych exam. They are under increasing pressure to do research and publish papers. This is particularly so since the introduction of *Achieving A Balance*, as research is construed as one of the major factors ensuring promotion from SHO to registrar. This, coupled with increasing competition for senior registrar and consultant posts, makes some degree of rivalry among trainees inevitable.

Thus, peer support is often sub-optimal and sometimes simply absent in training schemes. Individuals are at risk of being left to "sink or swim", and it is common for them not to know where to turn for help or advice. Psychiatric trainees in District General Hospitals, isolated from their medical colleagues, are especially vulnerable. The Collegiate Trainees Committee (CTC), through its members, is acutely

aware of these problems. Various approaches towards their amelioration have been suggested, including the following.

(a) For each training scheme to designate a trainee counsellor for consultation by trainees should they wish to discuss personal stress-related matters. Exactly who fulfils this role would vary from scheme to scheme. Some psychiatric tutors take this on themselves, though it is clear that this is far from universal practice. Indeed, many tutors believe that it is not appropriate for them to deal with such problems, and many trainees in turn worry that by revealing their problems to the tutor, they might be labelled as somehow "unstable" and have their career advancement prejudiced.

The CTC suggests that ideally the role should be filled by someone with appropriate training in counselling, who could be available at short notice, and who is idependent of the training centre itself. Trainees should know who this individual is, and the manner in which contact might confidentially be made. Of course, this is not to say that tutors or others involved with the training itself should refrain from taking on any counselling role. It will be up to individual trainees to consult who they will should they run into problems, but the availability of an independent counsellor can only serve to enhance the chances of trainees in trouble seeking appropriate and timely help.

(b) The support of peers should not be discounted. Fellow trainees are the only ones who really understand the stresses of individual schemes at any given time. They are therefore in many ways best placed to help trainees in trouble. Unfortunately, due to factors alluded to above, such peer support is often not terribly forthcoming. It is hoped that psychiatric tutors would take a lead in encouraging trainees to support each other. The election of a trainee representative should be encouraged, and he/she should see his/her role as facilitating support networks among trainees, as well as being the channel through which grievances can be aired. The election of trainee representatives to sit on various hospital committees, like the Division of Psychiatry and Training Committee, should also be encouraged. This would serve to facilitate flow of information from trainees to consultants and administrators, and give trainees experience in committee work. It would also enhance the role of trainees in decision making about broader issues of patient care.

(c) Regular meetings of trainees should be encouraged, and time allowed for trainees (expressly those in peripheral placements, who are often the most isolated) to attend such. Some training schemes organise regular groups for new intakes of SHOs/registrars, usually facilitated by a psychotherapist. This is very useful to some trainees, and should at least be on offer.

Of course, these measures will only provide the framework in which the necessary support happens. Without them, however, it can only be anticipated that stressed trainees will continue to "go it alone", with potentially damaging consequences for themselves and for their patients.

DAVID CASTLE,
Vice Chairman
OLA JUNAID,
Chairman
ROB KEHOE,
Secretary
Collegiate Trainees' Committee

Syllabus for MRCPsych Part 1

DEAR SIRS

I am writing to express my concern over an apparent anomaly between the declared syllabus for the Part I examination for the College Membership and the questions set in the recent Part I examination in October 1991.

The syllabus states that: "in neuroanatomy the candidate's knowledge of the brain and spinal cord ... should be updated as the basis of neurological examination and diagnosis. The motor and sensory systems and the autonomic nervous system should be understood to the same level".

The authors of a book of multiple choice questions, Dr Puri and Dr Sklar, have interpreted these requirements as *excluding* the autonomy and physiology of the limbic system, primarily because these areas are specifically itemised in the Part II syllabus (personal communication).

Certainly, questions appeared in the paper set in October 1991 on both the anatomy and physiology of the limbic system.

I would be grateful for clarification of this matter.

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Reference

PURI, B. K. & SKLAR, J. (1990) *Revision for the MRCPsych Part 1*. Edinburgh: Churchill Livingstone.

DEAR SIRS

Thank you for letting me see the letter from Dr Colgate. The content for both Part I and Part II of the Examination are set out in the Regulations. Dr Colgate correctly quotes the Regulations which give the content in broad terms.

Unfortunately, it appears that Dr Colgate has accepted the interpretation given in the book to which he refers. The Examinations Office has never, to my knowledge, hitherto given more detailed information