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## Why choose psychiatry? Report on a qualitative workshop

As trainees, we thought that examining the views of trainees who have already chosen psychiatry might add to our understanding of the factors involved in career choice.

In November 2009, the London Deanery School of Psychiatry hosted its annual trainee conference themed 'Recruitment – Everybody's Business'. There we facilitated two identical, optional qualitative workshops entitled 'Choosing psychiatry as a career – influencing the next generation'. Each workshop was attended by 30 individuals, and facilitated by 5 senior trainees and 4 medical students who took verbatim notes. Framing questions were used to identify key themes regarding positive and negative influences on career choice.

Of the 184 delegates, 86 (47%) were male and 106 (58%) reported Black and minority ethnic backgrounds. Two of us (M.P. and K.F.) used thematic coding until saturation of themes emerged. We report these themes briefly here.

Participants described the doctor–patient relationship, the human narrative ('psychiatry is about stories, rather than abstract algorithms'), and the rapidly evolving nature of psychiatry ('you can do things which are ground-breaking') as attractors to the field. They emphasised the importance of conveying the high work satisfaction and good work–life balance, job flexibility, and 'colourful colleagues [who make it] fun' to medical students.

Factors that nearly discouraged trainees from a career in psychiatry included stigma and negative attitudes towards the profession from colleagues. Several trainees described unhelpful experiences during their foundation years: being 'ignored by a consultant surgeon after disclosing an interest in psychiatry', and how physician colleagues 'did not have a positive thing to say about the specialty'. Medical student participants as a subgroup also commented on the effect of negative attitudes from other professionals ('boring job', being seen as 'less of a doctor' and 'becoming mad as a psychiatrist'). Such inter-professional stigma towards psychiatry has been reported to negatively influence choice of psychiatry as a career.[1,2] Intra-professional stigma and 'negative attitudes and behaviour' were observed among teachers, who were reportedly 'a bit embarrassed about being psychiatrists'. A further theme was the lack of professional confidence and evident role uncertainty among psychiatrists: 'Psychiatrists have big issues with the specialty they've chosen – we don't feel confident we're as valuable as other medical specialties; we're not sure what our role is and what we contribute'.

When trainee psychiatrists were asked what they could do individually and collectively to inspire the next generation, the main emphasis was on high-quality teaching and clinical placements, making time for experiential teaching, and helping students to feel part of the team. The importance of positive modelling by psychiatrists[3,4] was also noted, for example, being 'passionate about psychiatry'.

Changes in attitude and perception, both within and without psychiatry, along with improved student placements, role modelling and teaching quality must occur if we are to address low recruitment and, in the words of one of the participants, 'make the specialty something to aspire to, rather than something into which people drift'.

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## What about old age psychiatry?

We welcome the article by Oakley *et al*;[1] creating a robust training programme more focused on developing medical expertise will go a long way to addressing the identity crisis currently ravaging psychiatry. However, we were concerned about the proposed structure of postgraduate training with regard to the dearth of old age psychiatry experience. Currently, it is possible to undertake one, and in some cases two, 6-month old age placements at any point during core training. The proposed training reduces this significantly to one 4-month placement as a CT1. All other subspecialties are represented by 6-month placements between CT2 and CT4. It is unclear why old age psychiatry has been excluded from this. Although old age experience at an early stage in training is important, this can only serve as a basic introduction to the specialty and will not allow for the development of expertise and excellence as emphasised in the Tooke report.[2]

It seems perverse that the authors recommend increasing the total duration of training while reducing the time spent in old age psychiatry. To exclude old age psychiatry from CT2–4 placements suggests non-parity with other psychiatric specialties. We fear this may harm recruitment to the field, as it becomes a distant memory by the time choices for specialisation are made as a CT4. It neglects to tackle the situation of trainees who are undecided about old age psychiatry and would benefit from further experience to aid their decision, or those who have, early on, settled on a career



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in old age psychiatry and wish to consolidate their experience in preparation for ST5. The authors raise the issue of 'functionalisation' of general adult psychiatry and the risk that trainees may have very little exposure to in-patient treatment. That problem is resolved in the new proposals by two specific general adult placements each of 6-months. The new proposals do not equitably consider training issues raised by functionalisation in old age psychiatry.

Old age psychiatry is a multifaceted subspecialty incorporating aspects of psychiatry, physical medicine and neurology. This marries well with the authors' suggestion of incorporating more of these two disciplines in psychiatric training. Offering an older adult placement as a CT2–4 may help to maintain the momentum of focus on these skills, and enhance the expertise of all trainees.

1 Oakley C, Jenkinson J, Oyebode F. Psychiatric training for the next generation. *Psychiatrist* 2013; **37**: 25–9.

2 Tooke J. *Aspiring to Excellence. Findings and Final Recommendations of the Independent Inquiry into Modernising Medical Careers*. MMC Inquiry, 2008 (http://mmcinquiry.org.uk/Final_8_Jan_08_MMC_all.pdf).

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**Authors' response:** We are encouraged that our paper has sparked some debate of these important issues. We agree with Conn & Husain[1] that conducting emergency assessments out of hours is a crucial component of training in psychiatry. We also support the Section of Neuropsychiatry's view that evaluation of the practical aspects of implementing a more integrated curriculum would be beneficial.

We understand the arguments put forward by Burza & Hilton about the value of old age psychiatry and their assertion that it has non-parity with other specialties in our proposed scheme for postgraduate training in psychiatry. It was not our active intention to reduce trainees' exposure to old age psychiatry but this was a product of the challenge of trying to accommodate neurology, psychopharmacology and psychotherapy which currently are not routine placements. However, we intend our paper to stimulate discussion and would hope that this, and other perspectives, could lead to further shaping of a proposal for psychiatric training for the next generation.

1 Conn R, Husain M. Trainees want to work out of hours! *Psychiatrist* 2013; **37**: 117.

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## A meeting point for neurology and psychiatry?

Oakley *et al*[1] highlight an important training gap in the current curricula of both psychiatrists and neurologists. Among other interesting considerations, the article proposes that 'in the first year of training, a 4-month placement in neurology becomes an integral part of core training [. . .] to consolidate clinical examination skills and provide experience in the interface between neurological and psychiatric disorders'.

Historically, there is a tradition of cross-fertilisation between neurology and psychiatry, exemplified by the recent renaissance of the 'bridge' disciplines, neuropsychiatry and behavioural neurology.[2–4] Standards of clinical practice and applied research have benefitted from specialists trained in the assessment and management of behavioural symptoms resulting from pathologies of the central nervous system. In some countries, including the USA and Germany, the opportunity of exploiting these reciprocal benefits is already formalised with integrated curricula at postgraduate training level.[2]

In the UK, compared with their predecessors, psychiatry trainees have fewer opportunities to gain neurological and medical experience before specialisation. It has become increasingly difficult to move between specialties and there is little incentive for trainees to attain MRCP qualification. Over the past few years, the evolving discipline of neuropsychiatry has made some initial steps to bridge this gap.[3,4]

Based on these observations, the Royal College of Psychiatrists' Section of Neuropsychiatry agrees with the direction of the proposal by Oakley *et al* and encourages further discussion to translate valuable principles into practice. From the psychiatry trainee's perspective, achieving the College's core competencies (including working with patients with cognitive difficulties, neurodegenerative conditions) would be greatly facilitated by formal exposure to placements in neurology. The increasing necessity to optimise allocation and utilisation of healthcare resources would favour a revised curriculum, where the psychiatry trainee is provided with opportunities to learn about underlying neurological changes in traumatic brain injury, epilepsy or movement disorders. Trainees could also acquire the ability to diagnose conversion disorder based on physical signs (DSM-5).

Equally, care pathways which are currently far from efficient or cost-effective could be streamlined if the neurology trainee received exposure to the principles of conversion disorders and common behavioural symptoms and their management.[5]

Finally, we feel that the same principles should apply to colleagues dealing with neurodevelopmental conditions, where formal training of child and adolescent psychiatrists would benefit from incorporating core elements of the paediatric neurologists' curriculum. In other countries (e.g. Australia, New Zealand) additional training in paediatrics and neurology is available through dual training programmes and additional certifications.

It is important that we examine psychiatric workforce development needs in the context of advances in neurosciences research and our developing knowledge of brain functions and brain disorders. The members of the Section of Neuropsychiatry express their wish that the proposal for a more integrated curriculum gains priority in the agenda of postgraduate educational committees, where the practical aspects of its implementation should be evaluated in the light of economical and logistical implications.



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