Changing 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.

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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, liaising closely with 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 unanswered question that lies behind the current changes: do doctors have more to offer than nurses in the assessment and management of acute psychiatric emergencies?

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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 junior medical team 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 psycho-social 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...