

EDITORIAL

~PSYCHIATRIC TRAINING~

Psychiatry as a profession has advanced considerably since the establishment of the Hospital Authority. This is because the need for psychiatric services is better recognised, and for this reason a more adequate share of resources is now available. This has made it possible to compensate for the earlier deficiencies (Chen, 1985), and more posts are now filled without much difficulty. It is therefore about time for us to re-evaluate what we need for our profession so that we could better serve our clients.

The first task is of course to ensure that **psychiatric services** are run professionally and efficiently. This requires that our services are adequate in manpower and comprehensive in range. It might not be possible for us to compare directly with developed countries overseas in terms of provision for manpower. But we must bear in mind that as our socio-economic conditions improve, the demands by our clients for a better quality of services will increase. We need to have some targets in mind, for example, a more flexible population-based estimate of manpower, so that when the situation arises we are ready to make better plan for our future services.

Our **subspecialty services** are still in the process of development. We now have adult psychiatry, child and adolescent psychiatry, psychogeriatrics, forensic psychiatry, and perhaps community psychiatry and liaison-consultation psychiatry. We need to develop other fields such as mental handicaps, substance abuse, and psychotherapy. Of course, in subspecialty services, we need also to slowly improve the manpower. But this improvement will also be dependent on the demand of the community.

With the provision for adequate manpower and comprehensive range of services, we could then look at training for our **clinical trainees**. So far we have relied too much on overseas training. This was sensible in the past when we had inadequate training facilities. Now that we have begun to establish subspecialty clinical teams, we should make more plans to train our future psychiatrists locally. Any overseas training should be limited to our own areas of deficiency only. For example, in the fields of mental handicaps, substance abuse, psychotherapy, or even in the currently developing community psychiatry, it is important to allow promising senior trainees, especially those who have already had some subspecialty experiences in Hong Kong, to go overseas and receive advanced training for 1-2 years. On their return, they will be the pillar in pioneering their special fields. It is most disconcerting, and undesirable, for a candidate for a new appointment, say a consultant for a certain subspecialty, to indicate that he/she will learn to do the job after taking up the post. It is even more undesirable if a subspecialty consultant spends part of his/her time in another subspecialty, either because he/she is 'forced' to disguise the role as a result of manpower shortage in another specialty, or because he is incapable of developing a proper scope for his/her own subspecialty. Whatever the reason, how could one expect him/her to develop this subspecialty to the best of quality? Or, to train our senior and junior trainees well in that subspecialty?

At present the Hong Kong College of Psychiatrists has a blue print for our **senior trainees**. They have to be trained for a further three years after passing a mid-level diploma such as MRCPsych before the final examination for a Fellowship. This is timely and a welcoming decision. But the important point is what kind of training should they have after the mid-level qualification. The recently formed Working Group by our senior trainees reflects their concerns. In the U.S.A., the advanced training is usually spent in a recognised medical centre either as a chief resident or fellow in a subspecialty. In the United Kingdom, all senior registrars work half time in clinical service and teaching with a consultant in a subspecialty; the rest of the time will be attached to an academic centre so that he/she could be exposed to academic and research activities in one's own chosen subspecialty. In fact, the competition for a senior trainee's post in the U.K. is now so tough that it would be difficult to get one without some prior research experiences by the candidate.

For the **junior trainees**, they are currently well looked after by the Tutors' Committee of the Royal College of Psychiatrists of the United Kingdom. Their trainees' status is carefully scrutinized, and a Central Training Course is organized each year. However, we need to be more self-critical for the betterment of our clinical training. First, the clinical service of our junior trainees should be better supervised, and there is a need to provide active weekly supervision and weekly multidisciplinary ward rounds so that the work of our medical officers could be better supervised and assessed. It is undesirable to wait passively until they approach the consultant when they have problems. In fact, in the so-called British System, the registrar/senior house officer follows the consultant wherever he/she goes. Normally there is an equal number of consultant and junior post in the U.K. so that the juniors are supervised at all time. If our provision is to have more medical officers than consultants, then we need to think who will oversee the training of our juniors. Perhaps we could use the American system, so that residents are supervised by the chief resident in day-to-day clinical matters and by their consultants in other more selective clinical activities. Personally I have gone through both systems, and it is my personal bias that I prefer the British system of training, which is in my view more intensive and authentic. Such infrastructure is of course something for the HA to think about, as in the very near future we shall have to be weaned off from the British System and have to establish our own training system and professional examinations.

Second, the **Central Training Course** should become more professional, and the teachers should be properly remunerated. The remuneration not only would increase the motivation and better preparation by the teachers, it allows the Course coordinators to scrutinize the expertise of the teachers and the quality of his/her teaching, and to ensure that they are given the time to talk with the highest competence in the areas of their chosen special field. It is only in areas where there is no expertise in Hong Kong that we may allow people who had previously been marginally involved in that special field to deliver lectures. Even so, the better way is still to use the funds from the HA, or even through the Royal College of Psychiatrists (e.g. 1994), to invite the real experts from overseas to come and deliver a short course to compensate for our own inadequacies. Certainly the teaching should not be conducted by one who had just had an overnight quick reading as if studying for the MRCPsych.

I have so far left out the training for the **undergraduates and House Officers**, as these are dependent on the medical school authorities rather than on our profession as a whole. We who are working in the medical schools will no doubt try our best to promote the psychiatric aspects of medical training for every medical student. This is not only to expect more medical students to turn to psychiatry in future, but also to allow those who eventually choose other clinical disciplines to have the basic understanding of the psychiatric principles in medicine.

Char-Nie Chen

**Professor of Psychiatry
Department of Psychiatry
Prince of Wales Hospital
Faculty of Medicine
Chinese University of Hong Kong**

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