Hello! Welcome to this edition of the Registrar. We hope you enjoy reading, and if you would like to contribute to a future edition or simply would like to get in touch then please don’t hesitate to contact us via email at ptcsupport@rcpsych.ac.uk or tweet us at RCPsychtrainees! We look forward to hearing from you.

Dr Priya Rajyaguru
Editor

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Disclaimer: The opinions expressed in this magazine are those of individual authors and do not necessarily represent the views of the Royal College of Psychiatrists.
Hello and welcome to this edition of the Registrar!

Since the last edition the Psychiatric Trainees’ Committee (PTC) has been extremely busy! Over the last few months we have designed projects for the next year focusing on key issues affecting psychiatric trainees. These include sustainability of trainees whilst on call, restructure of the PTC web-pages and development of CT1 welcome events. PTC reps have continued to provide trainee opinion to the various college committees. Our primary role is to represent you ensure all trainees receive high quality training. To do this effectively we need your views and feedback, so please contact us via emailptcsupport@rcpsych.ac.uk or twitter @RCPsychtrainees.

Following from our national report “Supported and Valued” on trainee morale, we wanted to investigate further fatigue and sustainability for psychiatry trainees whilst working out of hours. Psychiatry trainees work within unique environment, often covering multiple sites over a large geographical area. Not only this, you may have worked several different types of rota through training. You will have seen over the last few months (and hopefully completed) the PTC designed national survey. We had one of the highest responses for a RCPsych trainee survey, with responses from all college divisions and four areas of the United Kingdom. The final report is now available here and the results were launched at this year’s congress. I wanted to say a big thank you to your input in engaging with the survey, and encouraging other trainees to do so also. We hope the recommendations from the report will improve on call environments for trainees across the country.

You may have noticed some changes when you access the PTC web-pages. As part of our work regarding engagement with trainees, we wanted to ensure accessing information about the PTC and its projects improved. We’ve changed some of the content to ensure it’s easy to read and relevant. We also reduced the number of pages to go through so it’s easier to find us, and given direct links to our email and live twitter feed, so it’s now easier to contact us too. We hope you like these changes, however we would love to hear your suggestions too.

In November and April we also held the first of our “CT1 Welcome Events” in London and Nottingham. This allows new trainees starting their core psychiatry programme to engage with the college directly and meet with college officers over an informal networking event. It was great for me to meet with trainees on both occasions, and I’m in the process of putting some of your suggestions for the PTC into practice. The next CT1 Welcome event” will be held in Scotland in August 2018.

Finally it was wonderful to meet so many of you at RCPsych International Congress in Birmingham. We want to continue to ensure we represent you, and ensure all trainees are supported and valued.

Please do get in touch, we’d love to hear from you.

Dr Charlotte Blewett
PTC Chair 2017-2018
Upcoming

IACAPAP 2018
23 – 27 JULY 2018, PRAGUE, CZECH REPUBLIC

UNDERSTANDING DIVERSITY AND UNIQUENESS

23rd World Congress of the International Association For Child and Adolescent Psychiatry and Allied Professions

Psychosomatic Medicine Congress 2018
25th International Conference on Psychiatric Disorders & Psychosomatic Medicine
July 11-12, 2018 Sydney, Australia
Faculty and Section Conferences

Faculty of Neuropsychiatry Annual Conference

**Date:** Thurs 13 - Fri 14 September 2018 | **Location:** RCPsych, London

Faculty of Child and Adolescent Psychiatry Annual Conference

**Date:** Thurs 20 - Fri 21 September 2018 | **Location:** Hilton Hotel, Glasgow

Faculty of Psychiatry of Intellectual Disability Annual Conference

**Date:** Thurs 4 & Fri 5 October 2018 | **Location:** Marriott Hotel, Liverpool

Faculty of Old Age Psychiatry Winter Meeting

**Date:** Mon 8 October 2018 | **Location:** London

Faculty of General Adult Psychiatry Annual Conference

**Date:** Thur 11 - Fri 12 October 2018 | **Location:** Millennium Gloucester Hotel London Kensington

Clinical Topics

15 Minute CBT for use in clinical teams: A Five Areas Approach

**Date:** Mon 22 October 2018 | **Location:** RCPsych, London

Liaison Psychiatry Trainees, Nurses and Allied Health Professionals Conference

**Date:** Thu 22 & Fri 23 November 2018 | **Location:** Mercure St Pauls Hotel, Sheffield

Working with Long Term Physical Illness & Medically Unexplained Symptoms

**Date:** Mon 26 November 2018 | **Location:** RCPsych, London
The case of Dr Hadiza Bawa-Garba has been at the forefront of many discussions amongst medical professionals for the last few months. The story has moved at a fast pace, with multiple stakeholders involved, including reviews ordered by the GMC and the Department of Health and Social Care into how gross negligence manslaughter (GNM) is applied in healthcare contexts. It is as yet unclear what this case will mean for the medical profession, but the anxieties it has driven are clearly present at the NHS coal face.

The facts
Dr Hadiza Bawa-Garba, along with nurse Isabel Amaro, were convicted in 2015 of manslaughter by gross negligence for the death of six-year-old Jack Adcock at the Leicester Royal Infirmary on 18th February 2011. Bawa-Garba was denied leave to appeal the conviction in 2016 and subsequently carried out her 2 year suspended custodial sentence. The Medical Practitioners Tribunal Service (MPTS) imposed a 12 month suspension, but not erasure, from the medical register in 2017 when examining her fitness to practice. This was overturned on appeal by the GMC in January of this year.

The appeal by the GMC sparked outrage across the medical profession, with many arguing that systemic and human factors had been ignored in the case. The transcript from the original criminal prosecution is currently not in the public domain, but when looking at the 2016 denial for leave to appeal and the MPTS ruling in 2017, it is reported that Bawa-Garba was covering for absent doctors, had not had a proper induction, was battling with IT failures and her supervising consultant was off site. Social media adopted the hashtag #iamhadiza, recognising that many junior doctors had worked in similar conditions - ‘it could have been me’ was the prevailing sentiment expressed.

Within a week, crowd funding had raised over £350,000, which has since resulted in the appointment of new legal representation for Bawa-Garba and the Court of Appeal granting a second hearing on her erasure from the medical register. Concerns were raised on Twitter by the Health Secretary about Bawa-Garba being struck off, resulting in the Department of Health and Social Care launching a rapid review into how GNM is applied in healthcare. The GMC have launched a similar review, chaired by Dame Clare Marx.

Concerns have also been raised about the use of reflective pieces in portfolios being used against Bawa-Garba. The Medical Protection Society (MPS), who represented Bawa-Garba until recently, have stated that this was not the case, however it remains true that documents contained in portfolios can be subpoenaed into court. This has prompted several position statements by medical Royal Colleges pertaining to the case and reflective practice, including that of the Royal College of Psychiatrists, who concur with that released by the Academy of Medical Royal Colleges. Essentially it remains a GMC requirement that reflective practice takes place, and that it must be sufficiently anonymised.

What does this mean for junior doctors?
This case has caused considerable unease within the profession. The feeling among many is that the GMC sought erasure in order to preserve public confidence within the....
profession. People rightly worry that the GMC, an independent body, is being swayed by public opinion (‘how can a doctor practice with a manslaughter conviction?’) more so than what is arguably in the best interests of patients as a whole (transparency and willingness to learn from mistakes – the ‘Duty of Candour’). This is a difficult argument to resolve with differing perspectives based on who you speak with.

The GMC have handled this very badly, with mixed and confused messages negatively affecting how doctors perceive their authority. Advice from their CEO, Charles Massey, made it clear that doctors are not to down tools where the system appears unsafe, but should raise concerns through existing mechanisms. This prompted the release of a very confusing flow chart.

Questions have been asked on whether the initial conviction was even correct, with the Queen’s Counsel barrister, Prof Ian Kennedy, asserting that GNM has no place within healthcare:

“We need to rethink the role of the criminal law and medical manslaughter. Does it have any place in how we deal with things going wrong . . . because medical manslaughter means that you can pick someone, blame them, and imagine that you’ve solved the problem. And what you have actually done is exacerbated it.”

As a junior doctor myself, I am left with a feeling of little faith in our regulator. The fact that they pursued Bawa-Garba’s erasure, but now have launched a review into whether GNM in healthcare is appropriate and are calling for reflective pieces to be legally privileged, makes me wonder where their strategy (or lack thereof) lies. By pursuing erasure, they missed an opportunity to lead on the needed discussion around GNM in healthcare, and instead have been forced into it by the profession they seek to regulate.

The Williams’ Review has recently reported and, when you take into account the tone of the report and read between the lines of the recommendations, there are some forthright statements. To paraphrase, it essentially says that GNM in healthcare is unclear and thus needs clarifying by the Coroner, The Crown Prosecution Service (CPS) etc.; that the CPS are incapable of taking human factors into account, so the CQC need to run a parallel local investigation where a Coroner refers to the CPS; that it’s currently too easy to be an expert medical witness; that fitness to practice proceedings are poor so the Professional Standards Authority must step in to rectify, because the GMC are incapable of doing so; that recorded reflective practice cannot be requested by the GMC during fitness to practice proceedings, and; that the GMC can no longer appeal the rulings of the MPTS.

Thankfully I have not been subject to the trying circumstances of Jack Adcock’s family or Bawa-Garba, but I am also now unsure about written reflective pieces in my portfolio. I am sold on reflection as a tool for professional development, but I’d say I’ve learnt the most through discussion, including talking about scenarios where things ‘went well’. I plan on continuing to do so, but I must confess that what is written in my portfolio is now even more anonymous than what it was before. And my trust in my regulator, the GMC, is at rock-bottom. I’m not sure what it will take to change this, a feeling that seems echoed by the findings of the Williams’ Review.

References

References cont
7. Cohen D. Bawa-Garba granted Court of Appeal challenge against erasure ruling. *BMJ* 2018;360:k1455
12. Rimmer A. The role of medical manslaughter must be reconsidered, says leading lawyer. *BMJ* 2018;360:k1376
13. Dyer C. GMC calls for law change to make doctors’ reflections legally protected. *BMJ* 2018;360:k1416
On the 31st December 2014 – somewhere in Scotland – a general adult psychiatry patient, Mr QR, put himself under the wheels of a moving heavy goods vehicle. He had been discharged from a psychiatric hospital 2 days earlier, having been diagnosed by a consultant psychiatrist with F61 Mixed Personality Disorder (with Histrionic and Anankastic Traits) and F68.1 Factitious Disorder. Sadly, QR did not survive his injuries which were clearly the result of a suicidal act. This was, in fact, the second occasion on which he had tried to place himself in front of an HGV.

As is the practice in such deaths, the case was investigated by the Crown Office and Procurator Fiscal Service (Scotland’s public prosecutor) and in July of 2015 they referred matters to the Mental Welfare Commission. The Commission has the power under the Mental Health (Care and Treatment) (Scotland) Act 2003 to carry out investigations where an individual with mental illness may have been subject to a deficiency in care and treatment. Their investigation sought to “identify what lessons can be learned from the experience of Mr QR and his family, not only for the health board concerned, but for all mental health services across Scotland.”

The investigation report was published in October 2017 and raised multiple concerns – several of which relate to team working, which in my experience is a perennial issue that both psychiatry as a profession and we as trainees should reflect upon. The Commission felt that the process by which the responsible consultant had reached his diagnoses was “seriously flawed”. They felt the consultant’s clinical focus was “fixed in its perspective to the exclusion of other more plausible diagnoses.” The Commission felt that the diagnoses were, in fact, misguided. There is a suggestion that had the consultant been open to a team view then this might have been avoided and matters may have taken a different course. Perhaps Mr QR would not have died?

The consultant had in fact sought a second opinion from a consultant colleague. That colleague felt that QR’s presentation did not meet the general diagnostic criteria for personality disorder. They felt unable to exclude a depressive episode. They suggested a trial of an antidepressant and told this to the consultant in person – stating to them that they could not support the current diagnosis. Ultimately medication was not restarted and notes say that the consultant intimated in the discharge meeting to family that the second opinion doctor had “excluded a diagnosis of mental illness.”

Of note the mental health nurses in the ward made excellent documentation of QR’s presentation. They documented that QR was struggling to have more than superficial conversations and that his mood was very labile. He was ruminatory and engaging in self-harm behaviours. He repeatedly sought staff attention but could then not bring himself to speak. He also displayed episodes of agitation. A clinical psychologist saw Mr QR for an hour and did not see any evidence to corroborate the personality disorder or factitious disorder diagnoses— they did not communicate this to the consultant however.

A review of the notes led an independent psychiatrist appointed by the Commission to state that he suspected that QR was much more likely to be suffering from a severe depressive episode, possibly with mood-congruent...
psychosis. However, many of the staff believed that the evidence they were collecting was consistent with a personality disorder, and staff attending ward round were almost always junior and seemed unwilling to
to challenge the consultant view. It appeared to the Commission that “any information the challenged or ran counter to the consultant’s thinking was rejected”. The consultant stated that he had sought advice and felt he did not need to follow the advice of a second opinion doctor. The Commission felt that the second opinion should have at least been acknowledged and the views of the clinical director should then have been sought given the incongruity.

In terms of the suicide risk it is interesting that the views of nursing staff differed markedly from the consultant as to the seriousness of the previous attempt of suicide by vehicle. QR’s named nurse felt “it wasn’t taken lightly by any means... from our point of view it showed just how unhappy he was and how desperate he was... I think it was taken seriously by everybody.” The named nurse stated “The consultant [on-call], I don’t believe, thought that he needed to be on increased levels of care, however I worried that he may need to be because he was alone.” The responsible consultant conversely told the Commission that he felt the nurses “were not entirely convinced that it was a genuine attempt.” Nursing holding powers under section 299 of the mental health act were also used on two occasions – though matters de-escalated to the point that detention was not required. It should be noted that for this power to be used the law requires nurses to consider it likely “that it is necessary for the protection of— the health, safety or welfare of the patient; or the safety of any other person” for the patient to be “immediately restrained from leaving the hospital” pending medical review. That suggests that they were concerned about suicide risk – but nobody voiced this to the consultant.

I think this case raises several questions about the way we practice and I suspect I am not alone in feeling this way. How many of us have been convinced that a patient has a personality disorder rather than an affective disorder? How many of us remember seeing a picture in our reviews that is completely different from that seen by colleagues from other disciplines? How easy is it to write-off the concerns of others and believe that we, as doctors and psychiatrists, have a monopoly on diagnosis? How often do we ask for a report from nursing staff as to ward observations, but then not ask for their interpretation of this? Do some nurses struggle to give their interpretation through fear of disagreement with the powers that be? Do we really listen to the MDT view or do we engage in selective abstraction and only hear that which we wish to hear?

In terms of my practice I’m now trying to think much more carefully about properly including other members of the MDT, respecting their view and using it in formulating management plans. For example, I now make a point of asking crisis nurses what they think about a patient we’ve just assessed before I’ll give my view. I am actively making myself open to challenge and I am keen to explore concerns in depth. I believe firmly that in psychiatry we are uniquely placed to be able to think about the motives behind other people’s viewpoints which should stand us in good stead to listen to others and to think about their alternative perspectives. Only then, I believe, can we prevent the sort of entrenched thinking that appears to have robbed Mr QR of a potentially different outcome.

References


But, how much time should you give for research?

It depends on how much you want to do; if you just want to get some experience and to fill a gap in your portfolio, you can either do it as a half-day/week using your research session, or a whole-day/week using both your research and special interest sessions. But, if you are someone who is really interested in research and think of it as a long term career prospect, you might think of giving it more than just a session or two/week. You could take some time out of training (OOP) - a six month or a year - to take a more active role in a current research project, or to even start your own project.

By the end of this time you should have achieved two main goals:

Firstly, you should have gained a deep understanding of the nature of academic work and how it looks/feels like being a full or a part-time academic compared with being a full time clinicians. This will put you in a better position to make a decision as to whether to pursue a career in academia or not.

Secondly, you would have built a good portfolio that makes you a good candidate for any available academic clinical fellow programme, should you decide to go for it.

So where to start?

In most NHS trusts there will someone who is responsible for research and academic programme (most probably a part time professor), whom you can approach to ask about the available opportunities, or if you have
an interesting idea, you can discuss it with them and get some advice as to how to start; they might even agree to supervise you or at least signpost you to someone who is willing to supervise you.

Another way is to get in touch with one of the local universities or research centres which has some links with your trust and talk to one of the professors there.

Try to make everyone else aware of your interest in research as you might have a colleague who is involved in a research project and needs some help or assistance.

As for me, I was lucky enough to have a colleague, Clinical Research Fellow, who happened to have been looking for a doctor to provide medical supervision for the candidates in a research project he was working on. So he offered me this role which I delightedly accepted.
Between Foundation training and Speciality Training I took time out to complete a Masters. My long term career goal is to specialise in Child and Adolescent Mental Health Services (CAMHS) and so I completed a Masters relevant to this. I chose to study International Child Studies (ICS) at King’s College, London as this course is "designed to promote a rigorous academic approach to contemporary issues in childhood" and given the potential for research and expertise to be found in London, I felt that there would be no better place than London to study a Masters related to CAMHS.

CAMHS is an excellent choice for those who like to employ a holistic approach to their patients and not only treat children as biological entities but also consider their feelings, emotions and relationships. In CAMHS the child is very rarely treated in isolation and the child’s family unit also requires support. Masters in ICS deepened by understanding and awareness of the psychosocial and cultural constructs of childhood and improved my understanding of the impact of the child’s wider network on his/her development. Given that childhood is a time of immense growth and development both physically and mentally, the impact of mental health disorders during childhood cannot be emphasised enough and can impact on the child’s whole life trajectory and potential. The knowledge and experience I have gained from studying ICS at King’s College will allow me to further develop my career as both a CAMHS clinician and as a researcher in CAMHS.

Having completed my undergraduate studies, postgraduate Masters and my Foundation training in London’s institutions, I know that there is significant clinical and academic expertise to be found in London. London has an excellent reputation for providing high quality patient care as well as high quality training in Psychiatry and working under the supervision of experienced senior academic doctors is a huge advantage in London and provides an excellent platform for Psychiatry trainees to further develop their careers.

London provides a well-structured and well-organised training programme whilst allowing trainees to tailor their training to their individual needs.

I was impressed to see the way that many professionals from varied disciplines worked together to ensure the best outcome for each individual.

This includes the opportunity for flexible working as well as allowing trainees to pursue their special interests. Given the vast and varied exposure that London Psychiatry trainees have, they are in an optimal position to pursue their interests further. Psychiatry trainees in London have extensive opportunities to develop their clinical competencies in a wide range of specialities and sub-specialities. Many specialist services operating at a national level are based in London and provide an excellent platform for trainee psychiatrists to pursue their individual interests and experience delivering mental health care at a national level.
London provides outstanding institutions for trainees to develop their careers including the world famous Maudsley Hospital which provides the widest range of mental health services in the UK. Institutions in London are also at the forefront of international scientific research and are world-renowned for the quality of their academia. This includes King’s College and the Institute of Psychiatry, Psychology and Neuroscience (IoPPN) which is ranked as the premier institution in Europe for the research, study and practice of Psychiatry and related disciplines and produces more highly cited publications in Psychiatry than any other university in the world. London is also home to the only specialist Biomedical Research Centre (BRC) for Mental Health in the UK. This centre aims for improved treatment, earlier diagnosis and individualised patient care as well as supporting the training of the next generation of researchers who will help deliver transformative change in mental health care. Not only is there a great potential for research but research findings are translated and implemented into clinical practice by practicing and promoting evidence-based medicine. This not only maintains high quality patient care but also ensures high standards of training for Psychiatry trainees in London.

As well as being home to several highly prestigious institutions, London also offers outstanding world class educational resources including over 120 libraries of which the largest is the British Library. This receives a copy of every publication produced in the UK and Ireland and is home to over 150 million items. If five items were seen every day, it would take 80,000 years to see the whole collection!

Training in London is truly a culturally enriching experience. It is a vibrant city which has the second largest immigrant population in the world (first being New York) and as 36.7% of London’s residents were born abroad, the world is truly represented in London. There are more than 300 languages spoken in London which is more than any other city in the world and as London is one of the most multicultural cities in the world with a population of 8.7 million people, Psychiatry trainees have access to a large and diverse population. This promotes the development of a broader perspective of mental health disorders and fosters an appreciation of how cultural factors impact on mental health. London has so much to offer and living here is a truly fulfilling experience as there is so much to do. With numerous attractions, a variety of restaurants providing worldwide cuisines, museums, art galleries and many parks with natural beauty, it is impossible to get bored in London.

London is undoubtedly the premier place to train and provides an excellent springboard for doctors to develop their careers as future Psychiatrists. London prides itself on the quality of its academic institutions and maintains its prestigious reputation by attracting and recruiting the very best doctors. Psychiatry training schemes in London aim to support doctor’s professional development in a rich and challenging environment to help trainees achieve their full potential. The multitude of benefits of training in Psychiatry in London ultimately produce the very best Psychiatrists to serve one of the largest, most dynamic, multi-cultural cities in the world.

References:
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World Congress on Mental Health, Psychiatry and Psychology
November 02-03, 2018 | Columbus,, Ohio, USA

Mental Health Summit 2018

Theme: ‘Leading Innovations and Therapeutic Approaches to achieve Mental wellness rather than illness’

ESSPD | 5th International Congress on Borderline Personality Disorder and Allied Disorder
27 – 29 September 2018 | Sitges nr. Barcelona, Spain

International Practitioner Health Summit 2018

The Wounded Healer
10 Year Anniversary Conference of the Practitioner Health Programme
Thursday 4 - Friday 5 October 2018
De Vere West One Conference Centre, London

19th INTERNATIONAL Mental Health CONFERENCE
Our Treatment. Our Environment. Our Strategies.
RACV Royal Pines, Gold Coast, Queensland
8th to 10th August 2018