

THE REGISTRAR

The Psychiatric Trainees' Committee magazine
Bumper Issue July 2020



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The **Psychiatric** Trainees' Committee

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Disclaimer: The opinions expressed in this magazine are those of individual authors and do not officially represent the views of the Royal College of Psychiatrists.



Editor's Introduction

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 'The Wounded Healer' [@ahmedhankir](https://twitter.com/ahmedhankir)

The production of the latest 'bumper' issue of *The Registrar* took place in the midst of the COVID-19 global pandemic ('bumper' because this issue boasts nine articles – more than double the average number we usually publish). The College, with input from the Psychiatric Trainees' Committee (PTC) Officers and representatives, has been busy preparing resources to provide support and guidance for trainees during this unprecedented and turbulent time. The PTC Officer's Update offers further information on how to navigate your training during the outbreak and its aftermath and the services that are available to help you cope, adapt and bounce back.

The theme of this issue of *The Registrar* is 'International Psychiatry'. This theme was conceived at a face to face meeting I had with our PTC Chair, Dr Ross Runciman, and RCPsych Training Manager, Kathryn Squire at the College headquarters in London (this was just before the national

lockdown had been imposed). As alluring as it was for the theme of this issue to be on COVID-19, we decided to remain steadfast to International Psychiatry because this continues to be an important and integral area in mental health. We understand and appreciate that we have a diverse readership comprised of trainees from all four corners of the globe and we value the international connections and collaborations that we have with partner organizations throughout the world.

The original plan was to print hard copies of this issue for release and distribution at the 2020 RCPsych International Congress in Edinburgh. The Congress was cancelled for obvious reasons and, to the assent of environmentalists, we had to resort to digital dissemination of this issue. That however in no way, shape or form, has diminished the quality of the content.

This issue of *The Registrar* yields important and interesting insights in international psychiatry from colleagues, companions and counterparts who I was fortunate to meet at events and conferences in the United States of America and Qatar. I was also fortunate to interview the President-Elect of the World Psychiatric Association (WPA) who, in his narrative, signposted his professional journey from Pakistan to the UK. Our WPA President-Elect also shared his vast knowledge about international psychiatry and global mental health. You do not have to travel overseas to appreciate the value of international psychiatry as illustrated by the founder of the International Conference on Mental Health at Cambridge University. This international conference held biennially at Cambridge provides a platform to network with students, trainees, consultants and professors who have brought their experiences and expertise to British shores for us to learn and benefit from.

This issue of *The Registrar* also contains poignant pieces about the RCPsych Certificate of Eligibility of Specialist Registration (CESR) pathway, endorsed by the General Medical Council that is available for International Medical Graduates as well as UK graduates. It was a pleasure and a privilege to invite an 'Expert by Experience' to contribute to this issue and his article about the importance of co-production in psychiatry training is a necessary and riveting read.

We hope you find this latest issue of *The Registrar* engaging, educational and entertaining. We welcome your feedback and invite you to submit articles for consideration for publication in future issues. In the meantime, please do take care of yourselves and stay safe.

PTC Officers' Update:

Working for you while you work for others



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Welcome to the July 2020 edition of the Registrar.

Firstly, and most importantly, we hope that you are well.

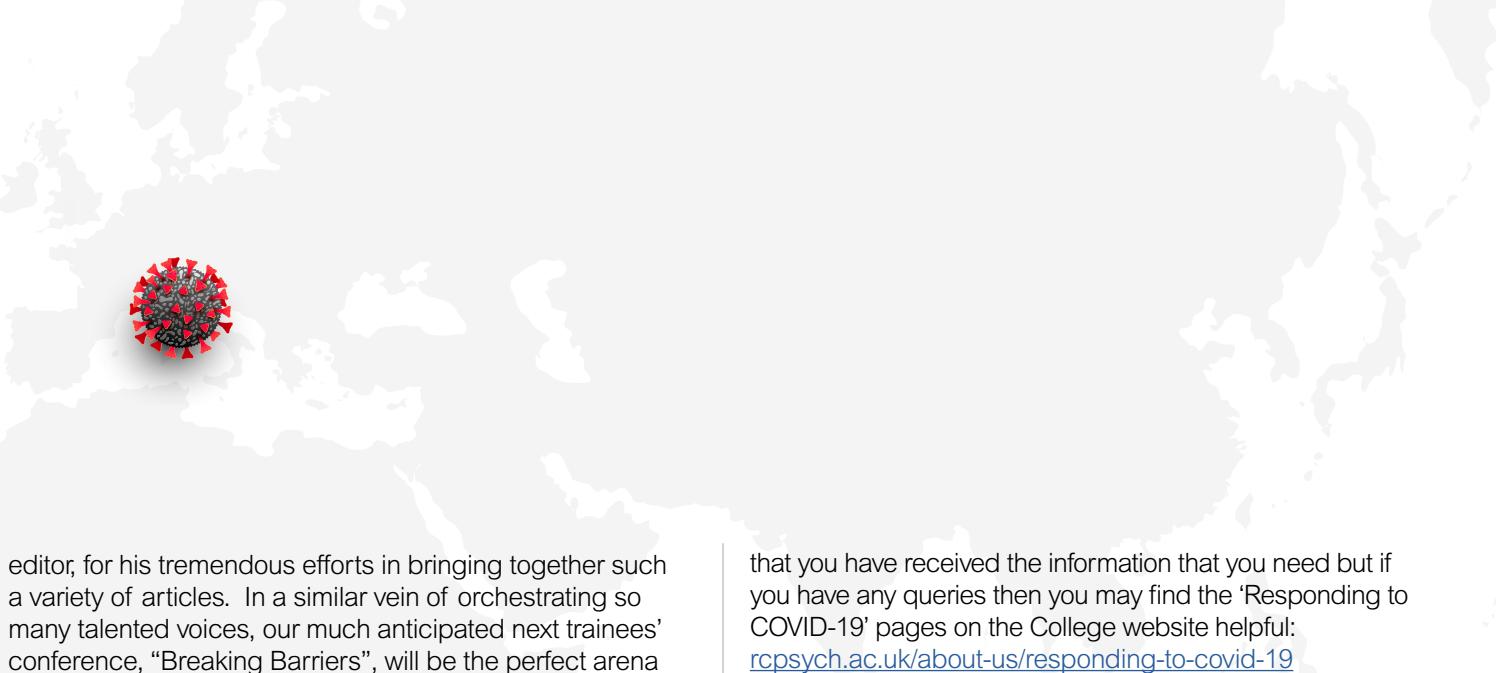
Secondly, thank you. For lots of things. For taking the time to read this publication when we are sure that your time at the moment is precious; for working so hard and flexibly in such challenging and worrying circumstances; for supporting our patients and their loved ones; for supporting each other.

Things have likely changed a great deal for you over the last few months. They certainly have for us. One thing that hasn't is our dedication in ensuring that the voices of psychiatry trainees are heard throughout the RCPsych. This is something we take incredibly seriously. We are proud to represent you, and be rest assured we have been working tirelessly on your behalf. Another thank you; this time for expressing your thoughts, concerns and suggestions to us. Engaging the trainee body is one of our top priorities and throughout this time we have been so pleased that so many of you have been in touch.

Whether this be through your local PTC representatives, email, Twitter, or the recent #RCPsychLive webinar on training matters. The latter was attended by over 970 people which is truly phenomenal, but if you weren't able to join us, you can view it through the link here: <https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians/elearning-covid-19-guidance-for-clinicians/covid-19-elearning-rcpsych-podcasts-webinars-and-videos>

The feedback received has been very positive.

The theme for this edition of the Registrar is 'International Psychiatry'. This was to coincide with the RCPsych International Congress due to take place in Edinburgh from the 29th June. Whilst we are disappointed that such a pivotal event is unable to go ahead this year, we will make it our aim to ensure that in 2021, our student and trainee lounge, "The Mess", is a hub of networking and development opportunities for you. We are confident that this publication will make for some interesting reading in the meantime and would like to thank Ahmed Hankir, the



editor, for his tremendous efforts in bringing together such a variety of articles. In a similar vein of orchestrating so many talented voices, our much anticipated next trainees' conference, "Breaking Barriers", will be the perfect arena to share the great work that you are currently doing. As soon as we are in a position to confirm the details of this conference we will of course let you know.

As you might expect, whilst the College continues to operate, staff are working from home to stay safe, and priorities have understandably altered to reflect the magnitude of the situation with regards to COVID-19. Whilst this has meant that some of our projects have taken a back seat recently, they continue to be works in progress and remain at the forefront of our agenda. This includes our mentoring, parental leave, staying well and International Medical Graduate (IMG) guides amongst others, but naturally we will update you as soon as we are able. A large piece of work that we have continued to move forward with is our social media platform. The aim of this is to allow psychiatry trainees to interact flexibly with each other as well as the PTC and College, to enable greater communication and sharing of opportunities. If you are anything like us you will have become very familiar, very quickly, with software such as Microsoft Teams, Workplace and Zoom to name but a few. It has been invaluable for us to continue to work together without being physically in the same room and we have been impressed by the positive attitude shown by fellow trainees who have really embraced new technology.

One benefit of some of our projects being on hold has been that we, as the PTC, have been able to focus more acutely on what really matters to trainees at the moment. Behind the scenes we have been liaising even more closely with the College to ensure that you are heard. We have influenced the adaptations to specialty recruitment, examinations and ARCP to name a few, constantly reflecting on the impact of these changes and what this means for us all as trainees. We like many people have felt sometimes overwhelming anxiety at the complexity and scale of this crisis. We hope

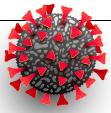
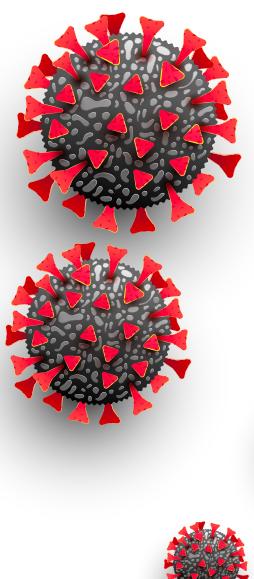
that you have received the information that you need but if you have any queries then you may find the 'Responding to COVID-19' pages on the College website helpful:
[rcpsych.ac.uk/about-us/responding-to-covid-19](https://www.rcpsych.ac.uk/about-us/responding-to-covid-19)

Although we see the tragic figures pertaining to deaths from COVID-19, we cannot afford to underestimate the detrimental impact that it is also having on mental health. There is the potential that when we are busy caring for patients, especially in such uncertain times, that our own mental health is neglected. We would like to encourage you to think about your needs, be kind to yourself, make time for yourself and if you need help or support, reach out to those around you. The Psychiatrists' Support Service (PSS) is one such option providing free, rapid, high quality peer support by telephone:
<https://www.rcpsych.ac.uk/members/supporting-you/psychiatrists-support-service>

Thank you once again and please, continue to keep in touch. As always, you can do this via your local representatives or through Facebook, Twitter or by emailing us at ptcsupport@rcpsych.ac.uk. We really appreciate hearing from you and receiving your feedback.

Stay safe and stay well.

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Universal Lessons Learned

Over 50 Years in American Psychiatry



Dr H. Steven Moffic

Though it may be hard to see, Dr H. Steven Moffic is wearing a tie from The Beatles collection with the song title "Help!" all over it, a tie he often wore at work. Now a private community psychiatrist in Milwaukee in the United States of America, providing pro bono help after a tenured career as Professor of Psychiatry at the Medical College of Wisconsin, he has always tried to fulfil Help's closing line plea of, "Won't you please, please help me, help me, help me, ooh!"

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"Those who cannot remember the past are condemned to repeat it"

George Santayana

If you are a psychiatrist in training, you can't learn from your past in psychiatry because you basically haven't had it. Instead, let me be your guinea pig and share some of my history about what I have learned from half a century in psychiatry. Though my experience is mainly in America, and indeed systems are different around the world, the essence of being a psychiatrist is similar anywhere.

TAKE GOOD CARE OF YOURSELF

After medical school at Yale, I began my psychiatric residency in 1972. It didn't take too long for me to become a Jungian 'Wounded Healer'. If you haven't already become one, you will. We are all wounded. The challenge is whether those wounds will leave us vulnerable or stronger. You can't take the best care of patients unless you put on your own oxygen mask first.

One of the first wounds I sustained as a psychiatrist was after an older man with depression who was receiving care from me died from suicide by walking into Lake Michigan. Every suicide is tragic but perhaps the saying that "one doesn't become a real psychiatrist until a patient dies by suicide" is true? I actually never had another until right before I retired...

The next deep wound occurred when I foolishly took some hashish for the first time, a stronger version of marijuana. I dissociated for a couple of weeks and felt "crazier" than my patients. Again, I was so fortunate to be sent to a compassionate therapist, where I learned more about myself as the drug was being eliminated. My wife, now of over 50 years, supplied the unending love that always made me stronger. Actually, in those days, personal psychotherapy was more or less expected, but not any longer.

Over these 50 years, as medicine has become more of a business in the USA, there has been a drastic change in the well-being of psychiatrists and other healthcare clinicians. As I discussed in the recent book I helped to edit, 'Combating Physician Burnout: A Guide for Psychiatrists', burnout was virtually zero back in the early 1970s. Some degree of burning out is now epidemic in psychiatrists in the USA and seemingly at concerning rates in other countries. The basic solution has become fairly clear: being supported, valued, engaged, and even loved by administration, while personally finding a "battle buddy" and trusted mentor. In other words, find your fit and nurture your network.



FOLLOW YOUR BLISS

Practicing psychiatry is never easy. The necessary empathy, treatment challenges, and administrative demands can be draining. One way to positively get through that is to find what you love to do most in psychiatry that connects to your authentic healing self, and do it as much as you can. Indeed, studies on burning out indicate that even 20% of your time devoted to what you prefer most is a major protective factor.

For me, early in my residency, I felt most concerned about the underserved, who generally were poor minorities. So that is what I have focused on despite the inadequate resources that our fragmented healthcare systems have always allocated for the poor, the social in our bio-psycho-social model. Eventually, that led to becoming the President of the American Association for Social Psychiatry at the turn of the new millennium. Now, given the continuing nuclear risk, along with climate change, toxic environments, and viral pandemics, I have proclaimed that the 2020s should be the decade of addressing the social ills of our world. That bliss, as recommended by the popular author Joseph Campbell, sustained me for most of these 50 years. More recently, that has translated into editing, along with three interfaith colleagues, one of whom being your own Ahmed Hankir, and an international group of chapter writers, two recent volumes on particular cultural topics: Islamophobia and Psychiatry, followed by Anti-Semitism and Psychiatry. Stay tuned for the third in the trilogy, Christianity and Psychiatry.

ESTABLISH THERAPEUTIC ALLIANCES

Some many years back I walked into a large waiting room to meet a new patient. When she came into my office, she said that she was glad I was her psychiatrist. This interchange was pre-internet checking for reputation, so I appreciatively asked why she said that. She replied: "I was watching other psychiatrists get their patients and you were the only one to smile upon greeting them." Best compliment I ever received.

I don't think that I was particularly knowledgeable about psychopharmacology or psychotherapies. Though cognitive-behavioral therapy has become increasingly popular, along with new generations of medications, and tele-psychiatry is now commonplace, the biggest variable is yourselves. Most psychiatric research on outcomes continue to affirm that the relationship is the essential therapeutic variable. First impressions are often lasting ones.

DEVELOPING A THIN AND THICK SKIN

Along the way, I received several professional awards, including the one-time 'Hero of Public Psychiatry' in 2002 and the 'Administrative Psychiatry Award' in 2016, both from our American Psychiatric Association (APA). Those were balanced by a colleague once calling me a "Nazi" at a meeting and a prior APA President calling me "evil" at another professional conference for being involved with managed care. Both apologized later and I ended up in 1997 writing the first book of its kind, called 'The Ethical Way: Challenges & Solutions for Managed Behavioral Healthcare'. Try to make lemonade out of any sour lemons.

RETIRING AND REWIRING

Historically, psychiatrists often worked until death. Our work was not particularly physically strenuous, and accrued wisdom seemed to outweigh any minor cognitive decline in old age. However, burnout has led many to retire early in recent years in the USA. I retired from clinical care 8 years ago when the leadership of my medical school reduced our scheduled medication follow-up visit time to 10 minutes.

I could only retire because we had saved enough money. I had enough outside interests to remain satisfied. Moreover, to my surprise, because our knowledge is relevant to almost anything in life, I have become a psychiatrist that helps with a variety of community needs. Begin preparing for retirement during residency.

May my history help your future...

International Psychiatry at its Best: The Biennial Cambridge International Conference on Mental Health



Dr Rashid Zaman

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Dr Zaman is also Director of the Centre for Mental Health Research in association with University of Cambridge (<https://www.cmhr-cu.org/>) which organises The Cambridge Biennial International Conference on Mental Health.

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This article traces the genesis and evolution of The Biennial Cambridge International Conference on Mental Health, exploring the reasons behind these conferences, our vision and what we hoped to achieve.

The origins of this popular international conference on mental health lie in a relatively small event that was organised by Dr Mark Agius (retired since 2015) in Luton,



Bedfordshire. Dr Agius used Beacon Fund money that he had been awarded to hold a small and somewhat local conference attended by academics and clinicians, largely focusing in the field of Early Intervention in Psychosis.

The evolution of the small Luton conference to its current form as a Biennial Cambridge International Conference on Mental Health began in 2005 when Dr Rashid Zaman joined Dr Agius as the lead organiser. It was at the direction of Dr Rashid Zaman, that the location of the conference was moved to Cambridge. Indeed, beside the name and location, the nature of the conference also changed as it began to cover wider aspects of psychiatry, including, epidemiology, culture, stigma, genomics, transcranial magnetic stimulation and international perspectives. The first Cambridge conference was held at Churchill College, University of Cambridge. It was then known as Luton/Cambridge International Conference on Mental Health and attracted a number of nationally and internationally renowned speakers such as Professor Peter Jones, Professor Paul Fletcher, Professor Kam Bhui, Professor Norman Sartorius, Professor Eva Palova and Professor Sir David Goldberg to name a few.

Two years later, the 2007 conference was once again held at Churchill College. It covered a wide range of topics on mental health and attracted eminent speakers beyond the UK and Europe, such as Australia (Professor Christos Pantelis) and the USA (Dr Hagop Akksal). It also included, Professor Peter Jones (Cambridge) and Professor Cyril Hoschl (Czech Republic), juggernauts in psychiatry who would subsequently become regular speakers.



The 2009 conference was opened by Cambridge University Regius Professor of Physics, Professor Patrick Sissions, and introduced by Professor Eugene Paykel. It was held at the Clinical School, University of Cambridge and saw the further expansion of topics in psychiatry, including contributions from Professor Ed Bullmore (UK), Professor Dinesh Bhugra (UK), Professor Norbert Muller (Germany), Professor Jiri Horacek (Czech Republic), Professor Juan Lopez Ibor (Spain) and Professor Patrick McGorry (Australia). This was the first conference in which we introduced a session on medical students in psychiatry. It included a presentation from two Cambridge medical students, Michael Gilholey and Abi Davis, as well as a prize-winning poster from a medical student from Manchester, Ahmed Hankir, who eventually became a member of the organising committee.

The aim of attracting medical students to psychiatry as a future speciality (not just in the UK) was attracting attention and gaining traction. We (Dr Mark Agius and Dr Rashid Zaman) had been working on this initiative through mentoring, teaching, and supporting Cambridge medical students' academic activities such as helping with their audits, research and publications. In order to push these activities to a higher level, we decided to make medical student presentations an important part of the Biennial International Cambridge conference by introducing a whole section devoted to them in the form of competitions with prizes.



Clare College Bridge, Cambridge

Therefore, the 2011 Cambridge Biennial International conference, once again with contributions from many eminent speakers from the UK, Europe and beyond, and held at Cancer Research UK, University of Cambridge (Addenbrooke's site), saw the introduction of a symposium titled, "Attracting medical students/new doctors into psychiatry" as well as a session titled, "International Competition: Best oral presentation by medical students & foundation doctors". There were presentations from medical students and newly qualified doctors from Belgium, Poland and the UK. Many of these presentations led to the writing up of research and audit findings, leading to publications in the *Psychiatria Danubina* supplement, a PubMed journal. For many of these medical students and newly qualified doctors, this was their first PubMed publication, which led to not only intellectual satisfaction, but also opened doors to future academic careers. Indeed, many of these medical students and newly qualified doctors who presented at the 2011 conference and at subsequent Cambridge Biennial conferences, have gone on to choose psychiatry as a career. From the feedback it was clear they were helped by their first publications from presentations at Cambridge Biennial Conferences. Indeed, many of these medical students have stated with pride that the presentations at Cambridge Biennial International Conference not only sparked curiosity about academic and clinical psychiatry, but also gave them the confidence and desire to pursue a career in psychiatry. We are pleased to see many of our former medical students and newly qualified doctors who presented at the conference (including the award-winning current editor of the *Registrar and South London and Maudsley (SLAM)* Academic Clinical Fellow, Dr Ahmed Hankir, Dr Ewa Debska (also a trainee in SLAM who first presented and published as a Polish medical student and Dr Jonathan Rogers, a Wellcome Trust Clinical Fellow at UCL and Specialist Registrar at SLAM to name a few)), occupying highly sought-after academic and non-academic training posts, both in the UK and in Europe. Indeed, some have now gone on to become consultant psychiatrists.



Picture 1: Some of the delegates, presenters and organizers of the 2015 Biennial Cambridge Conference posing for a picture

2013 saw major developments in the Biennial International Cambridge Conference. It was held for the first time at the charming Clare College, which is the 2nd oldest college of Cambridge University, and the conference has remained there since. Further expansion of the conference (packed with presentations and lasting 3 days) took place with a number of symposiums being dedicated to different countries (such as Belgium, Czechia, France, Italy, Poland and Middle East symposiums). One whole day was dedicated to an international presentation competition for medical students (36), trainees (13) and PhD students (18). This also led to PubMed publications for many of those taking part. Indeed, we are aware that many of the competition presenters have continued their career at top academic and non-academic training posts in psychiatry in the UK and Europe.

The 5th Biennial Cambridge conference of 2015, held once again at Clare College, Cambridge University was one of the largest, lasting 4 days (*Picture 1*). The first 3 days were devoted to many symposiums, covering wide ranging topics in psychiatry including, impulsivity (led by Professor Trevor Robbins) and immuno-psychiatry (led by Professor Ed Bullmore). Once again there were competition sessions for presentations from medical students and newly qualified doctors. It was particularly pleasurable to see some of the medical students who had presented at the 2013 conference to return and present as qualified doctors. The 4th day of the 2015 conference was largely devoted to humanistic, spiritual, philosophical, social and artistic topics connected with mental health thus giving the conference a truly eclectic flavour.

The Biennial Cambridge conference of 2017 returned to 2-day format, but maintained the high quality of previous conferences with presentations from international leaders in the field of neuroscience and psychiatry. A symposium devoted to teaching in psychiatry saw presentations from Dr Clare Holt and Dr Sophie Butler who had presented as medical students in one of our past conferences.

The most recent 7th Biennial Cambridge International Conference on mental health of September 2019 was attended to capacity (170) and maintained the very high academic standards of previous conferences with presentations from opinion leaders in the field of neuroscience and psychiatry, including, Royal College of Psychiatrists' President Professor Wendy Burn, Professors Trevor Robbins, Ed Bullmore, Peter Jones, Paul Fletcher, Christos Pantelis, Chris Baeken, Jiri Horacek, Naomi Fineberg, Barbara Sahakian, Rachel Upthegrove and Dr Golam Khandakar.



Gardens Cambridge



Picture 2: Some of the prize winners and organisers of the 2019 Cambridge conference

Posters presentations (30), together with international presentation competitions (Picture 2) for medical students (23), trainees (11) and PhD students (13) were combined with ample opportunities for networking which helped many to forge new friendships, form collaborations, and open up future career opportunities. As highlighted by Professors Trevor Robbins and Peter Jones in their conference dinner speeches, Cambridge Biennial International Conference's uniqueness is through their inclusivity, combining presentations from opinion leaders (in the fields of neuroscience and psychiatry), clinicians, early career scientists, trainees, PhD students and medical students. Furthermore, it continues to bring together researchers, clinicians, trainees, PhD students and medical students from the UK, Europe and beyond, fostering collaboration amongst the presenters and attendees.

So, what has made these Biennial Cambridge Conferences special and what did we hope to achieve? Experience and feedback have shown that Cambridge Biennial International Conferences have developed a certain uniqueness, through combination of high academic standards with inclusivity and maintenance of a friendly and charming atmosphere. The conferences are relatively cheap to attend with large discounts for students. We have also involved some medical students

in running of the conferences. A particularly popular part of the conference is the Conference dinner held at the Great Hall of Clare College (Picture 3) described by many attendees as reminding them of the Harry Potter film, preceded by drinks in the beautiful Clare College Scholars or Fellows Garden (Picture 4).



Clare College, Cambridge University



Picture 3: Dinner at 'The Great Hall' Clare College, Cambridge University

Bringing together individuals at various stages of their career (from the heads of departments to young medical students) from many parts of the UK, Europe and beyond in such a special surrounding is conducive of a most enjoyable and memorable form of learning. The feedback has shown that our Cambridge Biennial Conferences have been successful in bringing together individuals from many different countries, are of high academic standards, inclusive, conducive to learning and have shown some success in convincing many medical students to choose psychiatry as their future career speciality.

Finally, I would like to add that we plan to organise the 8th Biennial Cambridge International Conference on mental health in September 2021 at Clare College, Cambridge. We aim to make the conference every bit as academic, inclusive and charming in hopefully a post Covid-19 world, as our previous conferences.

For information on future conferences please visit
<https://www.cmhr-cu.org/>



Picture 4: Drinks reception at Fellows Garden, Cambridge University

My European Federation of Psychiatrists in Training (EFPT) Exchange Experience in South London and Maudsley (SLaM)



Dr Süreyya Melike Toparlak

Dr Süreyya Melike Toparlak is an International Medical Graduate. She is currently a CT2 in psychiatry at Stuttgart Clinic, Germany. She has a keen interest in poetry and music therapy and plays different kinds of musical instruments including guitar, piano and percussion.

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I completed the European Federation of Psychiatrists in Training (EFPT) Exchange Programme at the Royal Bethlem Hospital, which is a part of South London and Maudsley (SLaM) NHS Foundation Trust, in February 2020. The reason I applied to the programme was because I wanted to gain a broader insight into the mental healthcare system in the UK and to develop my skills in clinical psychiatry.

The EFPT Exchange Programme at SLaM is highly popular and applicants must 'compete' for a place. Shortlisted applicants are then invited for a Skype interview. The interview was challenging but enjoyable.

I was absolutely delighted to receive the email informing me that I had been successful. Following this, I received support from the local organizers at SLaM who helped to arrange a

Clinical Observership at Tyson Ward 1 at the Royal Bethlem Hospital. They also helped me to complete the necessary paperwork and to find suitable accommodation.

During my time on the acute adult male ward, I was given ample opportunity to develop my clinical skills. I also learnt about the legal framework in the UK (i.e. the Mental Health Act and the Mental Capacity Act). I was reminded how crucial communication is in interpersonal relationships during Multi-Disciplinary meetings and I observed how clear and effective communication with colleagues and patients alike is essential when it comes to providing high quality mental health care.

I had informative and educational discussions with my Clinical Supervisor, Dr Davies, about psychopathology which enriched my knowledge. Dr Davies also kindly arranged a rotation in the eating disorder unit under the supervision of Dr Himmerich. I had a great opportunity to attend ward rounds and to play a role in patient care and I felt valued and supported throughout the entire experience.

The EFPT Exchange Programme contributed to my professional and personal development. It helped as part of an ongoing project in Germany, in which we try to find out the most effective way to treat patients with addiction problems by offering an individualised and holistic approach to mental healthcare. The programme enabled me to network with trainees and lecturers as well as other team members, with whom I will keep in touch. This will be incredibly helpful for me as I intend to return to the UK for post-graduate psychiatry training.

To conclude, I want to thank my colleague Dr Alistair Cannon for his time, effort and hospitality, Dr Davies for contributing to my career development, all EFPT co-ordinators for their dedication and Charles Bowman for teaching arrangements in ORTUS educational centre at the Institute of Psychiatry, Psychology and Neuroscience (IoPPN). I will definitely inform my colleagues all round the world about EFPT Exchange Programme and share my amazing experience with them. I look forward to being a local exchange coordinator and completing another exchange programme as soon as possible.

A look at the Royal College of Psychiatrists' Curriculum from a Certificate of Eligibility for Specialist Registration (CESR) Perspective – Primary vs Secondary Evidence



Dr Nandini Chakraborty

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To CESR or not to CESR? That is the question

In 2009, I was a Specialist Registrar (SpR) in General Adult Psychiatry in Leicester. However, 18 months later I dropped out of my higher training post. You might incredulously be asking, “Why!?” The reason was because I had secured a Certificate of Eligibility for Specialist Registration (CESR) and a consultant job was already waiting for me. An interview on the 24th June meant that I had until the 24th December to take up the post. In a nail-biting race to the finish, the Post-graduate Medical and Education Training Board (PMETB) sent me

my certificate in early December 2011. Within a week I was on the Specialist Register and, after informing my Training Programme Director (TPD) and Head of School, I was appointed Consultant in General Adult Psychiatry on the 14th December.

The CESR route is open to anyone who has a specialist qualification or a minimum of six months in a training post in psychiatry anywhere in the world. Very rarely, people who are in a higher training post in the UK do decide to go through CESR by their own choice (as I did) but they have to be very clear in their minds about what advantage this brings them. A doctor with a Certificate of Completion of Training (CCT) in one specialty might also decide to apply for CESR in another specialty. For example, a doctor with a general adult psychiatry CCT working in a forensic or intellectual disabilities setting might want to consider pursuing the CESR pathway in their working specialty if that brings them satisfaction or is practically more advantageous. MRCPsych is not a prerequisite for CESR applicants and our experience in the Equivalence Committee shows that the proportions of success within candidates with and without MRCPsych are fairly equal. This might be counter-intuitive but it is true.

My CESR journey

In the 10 years following the acquisition of CESR, I have heard a number of interesting comments. The ill-disguised surprise when people hear that I have a CESR not a CCT, the gossip I can be privy to (because most people cannot tell I have a CESR!) which calls CESR consultants the ‘backdoor specialist’ and the ‘short-cut’ to the Specialist Register and the prognosis of doom and gloom of a career that follows CESR instead of CCT.



Having been a Specialist Trainee for 18 months and having gone through the CESR route, and also having been a TPD and an MRCPsych course organiser at the same time as being a CESR evaluator in the College, I occupy a very fortunate and unique place where I can comment on these two routes leading to the Specialist Register of the General Medical Council (GMC) first-hand. My overall view is that CESR and CCT need not be seen as competing at all. There are lessons to be learnt from both journeys. In their essence they are held in the same esteem by the College. They share in common the extensive Royal College of Psychiatrists' training curricula documents that uphold the excellent quality of training provided in the UK and the extremely high standards we expected from consultant psychiatrists and trainers of a future generation. What trainees need to achieve is outlined in Intended Learning Outcomes or ILOs. How do they achieve this? That is what a training rotation or clinical placement provides in way of opportunities, supervision and guidance. How does a doctor evidence that competencies have been achieved? That is where a CCT candidate at the Annual Review of Competence of Progression (ARCP) panel and a CESR candidate at the CESR evaluation panel start having differences in approach.

Primary vs secondary evidence

How do I prove my clinical competencies to someone who has never observed me working and who has never heard anything about me?

Psychiatry is a specialty where opportunities to collect primary evidence of clinical work to prove your competence is abundant. A clinic letter can evidence history taking, examination, formulation, diagnosis and risk assessment. A statement that this assessment took place on request of a colleague further evidences team working, collaboration and communication. The date of

a letter being dictated is evidence of time management. Record keeping, written and verbal communication, the professional relationship with the patient, carers and other organisations - can all be evidenced in a well written letter. A number of letters done in different clinical settings, providing care to patients from diverse backgrounds, showing independent management of increasing complexity can all demonstrate clinical learning outcomes without the explicit statement of whether a doctor is working below, at or above their expected levels.

So that is primary evidence- where no one makes a statement about the doctor but the evidence speaks for itself. Clinic letters, medico-legal reports (including tribunal reports), electronic notes, psychotherapy notes, emails (especially the ones which show a doctor stepping up to do a presentation or on-call at short notice or volunteering for that job no one else will take up), audit and research reports and publications. Professional meetings which show a doctor taking a lead in a complex patient or clinical situation make great evidence for leadership. Leadership courses are fine but without application in practice they mean little where competencies are concerned.

So, what does my supervisor think of me? Work Place Based Assessments (WPBAs), supervisor reports, testimonials, 360-degree appraisals/Team Assessment of Behaviour forms and references – these would all be considered secondary evidence. Important in its own way since it shows how people perceive us but it nonetheless remains a second-hand report to an observer who does not know the doctor. Secondary evidence is essentially what the others think of you.



The difference between a CESR evaluation and the ARCP process is this- primary evidence versus secondary evidence. A CESR evidence bundle is an applicant trying to directly show the evaluators that they function at the level of a consultant through their work. For an ARCP there are 'no surprises'; the WPBAs, Educational Supervisor and Clinical Supervisor reports have pre-decided it all.

I must admit that I love the primary evidence approach. It becomes a habit for yourself once you have been on that journey. I still adore storing in a separate folder at work- my most complex assessments, the complimentary emails from colleagues, the work done in academic, management and clinical settings. Not everything needs a certificate or a testimonial. There is evidence in anonymised letters, emails, project reports- nothing should be lost. It is your record of your career which you never know when you need to fall back on. The ability of knowing how to prove your competence without having someone to comment on it is, in my opinion, a fine art.

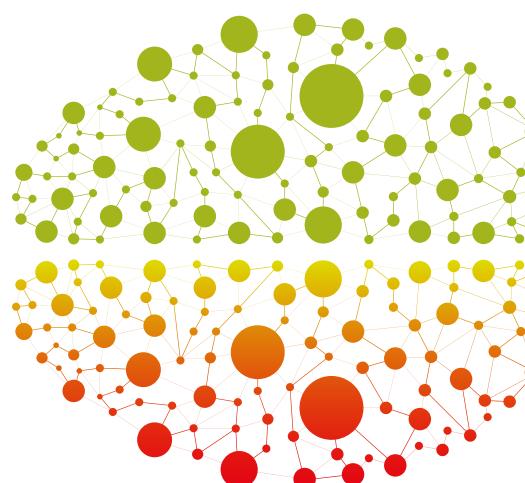
Using primary evidence to resolve a situation between a trainee and a trainer

One of my favourite stories during my tenure as TPD was using primary evidence to resolve a situation between a trainee and a trainer. The trainee felt unsupported and pushed to service provision without attention to training needs, the trainer felt that the trainee was performing below standard. A few assessment letters and tribunal reports were all I needed to make up my mind independently. Another moment of realisation was when I was formulating a Professional Development Plan (PDP) with an educational supervisee about to go for an addictions post. I would never have guessed intuitively that our addictions curriculum asks for experience in gambling addictions, addictions in prison settings and in pregnant mothers. We very satisfactorily managed to negotiate with the Clinical Supervisor to arrange

for special placements. I do sometimes wonder how frequently we read the curricula unless it is ARCP time. Hopefully with the new RCPsych curricula we can make a fresh start where trainees and trainers actually refer back to them time and again during a placement.

My take-home message:

The essence is to be proud of the work we do, beyond a tick box approach- the minimum number of WPBAs, the psychotherapy 'case', the 'audit report', the 'reflections'- all leading to 'the e-portfolio'. There will be many portfolios waiting for us later- as appraisals teach us. The approach to collecting evidence as a checklist versus evidence that proves our clinical excellence may very well prove to be the difference between satisfaction and burnout...



Certificate of Eligibility for Specialist Registration (CESR) in General Adult Psychiatry – A First-Person Account



Dr Hal Abdullahi

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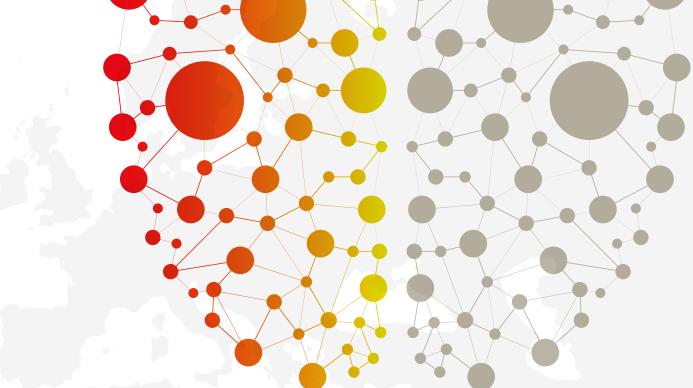
My first experience of psychiatric practice in the UK was between 2015 and 2017 as a postgraduate trainee within the Medical Training Initiative (MTI) Scheme organised by the Royal College of Psychiatrists. Within a few months of my MTI fellowship, I realised I wanted MRCPsych as a post-nominal, in addition to my longer-term plan to work as a consultant in general adult psychiatry.

As an International Medical Graduate (IMG) who had completed psychiatric training outside of the UK and who wanted to work as a consultant in the NHS, I had to

give consideration to applying for specialist registration via the Certificate of Eligibility for Specialist Registration (CESR) pathway.

On completion of the MRCPsych exams and just before the end of my MTI fellowship, I was invited for an ST4 training interview for general adult psychiatry. At about the same time I was offered a locum consultant job in psychiatry. Several factors including the need for stability, the offer of work at consultant level, better remuneration and a promise of support by the recruiting Trust meant that I opted for the locum consultant post. It also meant that I was embracing more uncertainty and a potentially more tedious process when compared to undertaking higher training. I anticipated that I should complete training by August 2020 if I had opted for higher specialist training, hence I set that as the time limit for my attainment of specialist registration via the CESR route.

I did not achieve much in my initial months as a locum consultant as I had to adapt to living in a different part of the country, a new role, new colleagues and a sector-based model of care encompassing both community and inpatient work. With the support of assigned mentors, I focussed more on attaining Approved Clinician (AC) status which was integral to my day-to-day working and more realistically attainable in the shorter term. Importantly, some reflective pieces, 360 multidisciplinary feedback, tribunal reports and attended courses which formed part of my AC application package, doubled as evidence for my CESR application.



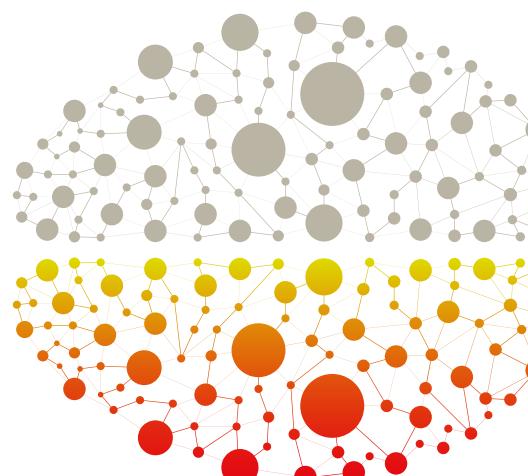
A variety of 'stars' I had to align for me to gather requisite evidence for my CESR application in my second year as locum consultant included;

1. Having the right job, which provided me the opportunity to work contemporaneously in both community and inpatient settings and as such, meant that evidence was not difficult to come by.
2. Familiarising myself with and taking note of the inextricable linkage between the Intended Learning Outcomes (ILOs) as per the curriculum for General Adult Psychiatry higher training, and the evidence listed in the GMC 'specialty specific guidance' on documents to be supplied as evidence supporting an application for entry onto the Specialist Register with a CESR for General Adult Psychiatry.
3. Employers who via a proactive medical education department organised helpful CESR workshops and a peer support group specifically focussed on sharing information relating to the CESR process as well as providing a platform for prospective applicants to network. Importantly, I had specific Supporting Professional Activity (SPA) time job-planned to further my CESR related professional development.
4. Advice from experienced CESR assessors and GMC specialist applications advisers.
5. An external CESR workshop I attended from whence I realised the importance of quality over cumbersomeness.
6. Encouraging colleagues through their supportiveness for Work Place Based Assessments (WPBAs), learning from their experience, provision of references and helpfulness in verifying submitted evidence.
7. An understanding toddler and a supportive wife.

I had to create my own constellation out of the aligned stars through focussing on well organised, mostly triangulated evidence aimed at meeting the ILOs for General Adult Psychiatry. Adopting a positive mind-set and sheer perseverance helped when the going got tough.

I started actively gathering CESR related evidence only after my attainment of AC status. It took about a year and half after that to get a successful decision from the GMC in April 2020.

Overall and with the benefit of hindsight, the CESR application process was somewhat challenging but not as daunting for my 'experiencing self' as I had anticipated beforehand. I was able to achieve specialist registration at my first attempt at applying and within my target timeframe. In addition, I now have 2.5 years of UK consultant experience on my CV and as such my 'remembering self' is quite grateful to have completed the process.



The Importance of Co-Production in Post-Graduate Psychiatry Training



Simon Rose

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“The practice of medicine has changed over the past 50 years. One notable change has been a move away from the traditional deference of the patient to medical authority towards a more active role for the patient, who is now becoming ‘person’ rather than ‘patient’. Medicine as a whole is becoming more person-centred...”¹

“Psychiatry is focused on the person; it is impossible to practise psychiatry well without listening carefully to a person’s concerns and making them the focus of clinical attention. A collaborative approach to care is fundamental...”¹

Permit me, if you would, to begin with a question. In an age where collaborative approaches to psychiatric care are ‘fundamental’, how many of the 50 or so articles, letters and editorials published in ‘The Registrar’ over the last 5 years have been written by non-medics? Include psychiatric nurses, occupational therapists, social workers, patients and carers in your thinking. What do you reckon - 10%? 20%? I could actually find one article and one piece from a guest editor. And that includes contributions in an edition entitled, ‘What I have learnt from my patients.’²

Of course, this is unsurprising and I am not aiming here to be provocative or antagonistic – ‘The Registrar’ is the magazine of the Psychiatric Trainees’ Committee of the Royal College of Psychiatrists and is aimed at a readership of psychiatry trainees. However, given these figures, it is with some trepidation that I am raising my head above the parapet to argue that stronger collaboration between trainees, education providers and those of us with lived/living experience of mental ill-health has the potential to improve the knowledge, and, more importantly, attitudes and skill-set of trainees as they progress through post-graduate psychiatric training. Further, it has the potential to challenge mental health related stigma and to start to reframe the clinician/patient relationship, shifting power imbalances to support more collaborative person-centred models of care.

An introduction may be helpful at this point. My name is Simon Rose and I have a fairly unique set of skills, attributes and experiences. I combine a post-graduate qualification in medical education with almost 25 years' worth of living with mental illness. Over that time I have spent more than 18 months in acute in-patient settings, been through a 'day hospital' and have undertaken psychotherapy twice a week for 2 years.

My experiences have led me to formulate a belief that wisdom, knowledge and skills are derived from many different places – whether that be textbooks, working clinically as a doctor/nurse/occupational therapist, practice as a social worker or, significantly, from having lived/living experience of mental illness or distress or caring for somebody who has such experience. If clinicians truly want patients to receive person-centred care, it feels important that we draw on a range of those sources of knowledge. My beliefs here fit neatly with the concept of co-production, the idea of an equal partnership between people who provide care and people who receive it. In a medical education framework, I am thinking in terms of equal partnerships across all parts of the educational process – from developing curricula right through to assessment. Drawing on the knowledge and wisdom of all parties in equal measure.

I am currently employed by Derbyshire Healthcare NHS Foundation Trust as a Lived Experience Educator. I work with undergraduate medical students from the Universities of Nottingham and Sheffield, tasked with helping them to access the knowledge that comes from lived/living experience of mental illness. In doing so, I am privileged to work alongside a group of around 50 'expert patients' who allow students to access parts of their lives – specifically to help their knowledge and understanding. There is a strong evidence base in the literature to suggest that the things that shape practice and support development of a healthy culture are learning from narrative. Real life is so much more powerful than PowerPoint!

My understanding is that post-graduate teaching programmes may use simulation and other similar techniques to help shape the skills of trainees. There is clearly a place for these; however, there is also the possibility for so much more depth and texture to knowledge that stems from someone who actually understands mental illness 'from the inside'. For example, if you want to fathom why young women are reticent to take anti-psychotic medication to get relief from hallucinations it is probably helpful to comprehend the struggle between being 'well' on medication but overweight in a society that stigmatises obesity and being 'unwell' without medication in a society that stigmatises mental illness. A doctor can tell you of the struggles, an actor can guess – but someone faced with those decisions can explain what it feels like 'in the inside' in a way that nobody else can. And the evidence is that knowledge gleaned via this method sticks – and will help to create doctors comfortable working in a person-centred way; understanding that decisions are never straightforward (even if they are seemingly obvious) and looking to work collaboratively with their patient to achieve the best outcome and patient experience.

My belief is that this way of working is transferable to post-graduate training, will be of huge benefit to trainees and ultimately those of us who receive care from you. Of course, the hierarchies of medicine and medical education will mean that you, as trainees, will have limited influence of what, or how, you are taught. The aim of this article has been to stimulate you to think about how training could be done differently, collaboratively and in a way that promotes patient autonomy and to suggest that you could start to have conversations in this area in your Deaneries and Schools. My take home message is this: by the time you are in a position to shape the future remember that if you do the same as you have always done, you will get the same results as you always have.

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Crying Out for Perinatal Services in Northern Ireland



Dr Keira Walsh



Dr Michael McMorran

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There is a large body of evidence that women can become severely unwell in the perinatal period and mental health services to support and treat them have developed across the UK. In the last decade, recommendations (RCPsych, Department of Health, NICE and local independent reviews), have unanimously reported that women should have access to specialist perinatal community services and a mother and a baby unit (MBU).

Despite this, in Northern Ireland (NI) we have extremely limited perinatal mental health service provision available. We currently have one small team in Belfast, with no services available in four of the five Health and Social Care Trusts, and no access to a local MBU. In NI we have higher psychiatric morbidity than the rest of the UK.

In order to evaluate the need for perinatal services in NI a regional audit was completed in 2013 to estimate the number of women who required care under acute mental health services in the perinatal period. Data was collected over a period of 32 weeks and showed that 32 women required admission to a home treatment team and 43 required admission to an inpatient ward. This data was extrapolated to estimate that 122 women would require treatment in acute mental health services over a 12-month period.

This information was helpful to demonstrate that there is a need in NI for both community and inpatient perinatal mental health services. As plans progress to address these needs, we wanted to update this information by completing a re-audit. We obtained permission from directors for each of the five Health and Social Care Trusts in NI. Information was gathered regarding pregnant women and those up to one-year post-partum prospectively by phone calls to the acute admission wards and Home Treatment Teams. The data was collected for all Trusts over 3 months from January to March 2018, with data gathered for 3 Trusts for 12 months. There were some obstacles to data collection which highlighted the lack of coding for perinatal patients and emphasised the importance of this. The results are displayed in table 1. Data was also obtained about length of stay and diagnosis. The results are comparable to the 2013 audit and may even represent an increased need.



	HTT Admissions	Inpatient Admissions	Total Admissions	Total in 1 year (extrapolated)
Results of Data For 3 Months - All Trusts (Jan – March 2018)	27	15	42	168
Results of Data For 1 Year - 3 Trusts (Jan – Dec 2018)	66	30	96	-
Results of 2013 Audit (32 Weeks Data Collection)	32	434	75	122

Table 1: Results of audit on perinatal mental health service utilization in Northern Ireland

As we are aware, admissions to an MBU can be for women who are unwell but also prophylactically for those at high risk of becoming unwell in the perinatal period. At present, there is one small perinatal mental health team (PMHT) in Belfast which, along with the Home Treatment Team (HTT), has developed a specialised model for managing higher risk women in the perinatal period in the absence of an MBU. Women are identified for this service by the PMHT and will usually have a history of affective or psychotic illness. They will initially have a care planning/pre-birth meeting at 32-weeks (or later depending on referrals) which includes discussion around presentation (past and present), medication, delivery and post-partum plans. The HTT will become involved before birth (usually at 38-weeks) and will also see the woman after delivery in maternity before she is discharged home. They will offer support and closely monitor mental state along with the PMHT in the highest risk post-partum period.

To evaluate the service, we reviewed the notes for all the patients who had been treated since the development of the service in 2014. We also requested patient and staff feedback via posted questionnaires. We collected data about referral, diagnosis, partners, pregnancy complications, care planning meetings and HTT involvement prior to birth. We also obtained information on length of stay with HTT, whether inpatient admission was required, duration of admissions and whether the Mental

Health Order (NI) 1986 was used. This demonstrates that, whilst services in Belfast are able to safely monitor and treat women in the perinatal period, hospital admissions will still be necessary at times. There remains a core group of women who become so unwell in this high-risk period that they cannot be managed outside a hospital setting and they should ideally be treated in a MBU. Patient feedback highlighted the good work being done by the service but also the distress that was caused by being admitted to a general adult ward and separated from their baby.

In summary, there are numerous recommendations that women should have access to both mother and baby units and community perinatal mental health teams. We now also have specific evidence from Northern Ireland to suggest that there is demand for these services locally. Positive steps are being made in the discussions and plans for developing perinatal services and it is hoped that we will be able to provide the care that women need in the near future.

With special thanks to Dr Janine Lynch and the Perinatal Mental Health Team in Belfast.

Psychiatry Residency Training in Doha, Qatar: A First-Person Perspective



Dr Ali Khalil

Dr Ali Khalil MD CPHQ is a senior psychiatry resident at Mental Health Services of Hamad Medical Corporation (HMC) in Doha, Qatar. Dr. Khalil was elected by his colleagues as Psychiatry Residents and Fellows Representative to the 'Trainees Council' of Hamad Medical Corporation. He was further elected as the chairman of the 'Trainees Council' which is an independent body under the graduate medical education department of HMC. Dr. Khalil is the founder and director of the Wellness Ambassadors Project; an evidence-based initiative aiming to improve mental health literacy and reduce mental health related stigma in Qatari high schools.

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I am humbled to be given the opportunity to write this article in your magazine. My name is Ali Khalil and I am currently in my final year of psychiatry residency training (core specialty training) at Hamad Medical Corporation in Qatar. Being only a few months away from completing my core psychiatry training, I am excited to take you through my journey. But before we do that, I must take you for a quick detour down memory lane and tell you why I chose to become a psychiatrist...

Towards the end of the first year of medical school in Egypt, I started noticing a change in my best friend's behaviour. He started to become distant and more socially isolated. He was also a bit sensitive and would misinterpret anything I would say to him. He started skipping lectures and his grades plunged. At that time, we did not know much about psychiatry or mental health. I thought, "Maybe he is going through a phase or maybe he does not want to be friends with me anymore?" It was not until a year later that he was diagnosed with schizophrenia and unfortunately, by that time his chance of a complete recovery were much slimmer. During this year we went through all the stages most of our patients go through; dismissal, confusion and denial. I saw how the illness changed his life. I saw how he was outcasted by his society, friends and even his own family. This experience put me on the path of psychiatry.

After graduating from medical school, I started my core medical training in Egypt, then I decided to move to the United States (US) seeking better training and



education. After spending nearly two years in training in the US, I found the opportunity to start core psychiatry training in Qatar. From the first day of my training here, everyone has been extremely friendly and supportive. It felt and continues to feel like a small family. I feel truly blessed to be surrounded with amazing colleagues and mentors who shaped my professional and even personal life and made me who I am today. We are blessed with having a diverse group of consultants and faculty from various nationalities and training backgrounds; from the Middle East and North Africa (MENA) region, USA, UK, Canada and Australia. This gives us as trainees a varied and rich training experience. Another advantage we have here, is that our hospital is the main public service provider in Qatar and the only hospital that has inpatient psychiatric services. This provided the opportunity to see large numbers of cases.

Our training program is four years long and follows the same curriculum and evaluations as in the US. Hence, it is accredited by the Accreditation Council of Graduate Medical Education- International (ACGME-I). HMC is also accredited by the Joint Commission International (JCI) as an academic institute. The training is composed of consecutive rotations depending on the year of training.

During the first year we train in inpatient psychiatry, neurology, general medicine and emergency medicine. In the second year, we train in consultation liaison psychiatry, community psychiatry, addiction psychiatry and inpatient psychiatry followed by part 1 exam for the Arab Board of Psychiatry. During the third year, we train in child and adolescent psychiatry, old age psychiatry, outpatient clinics, psychotherapy and inpatient psychiatry. The final year consists of a few inpatient rotations and forensic psychiatry rotations as well as elective rotations where we get the chance to choose any of the aforementioned subspecialties based on our interests and future plans followed by the 2 final exams for the Arab Board of Psychiatry.

After finishing the residency training program, we have a few fellowships to choose from based on our competency and interests. The available fellowships so far are:

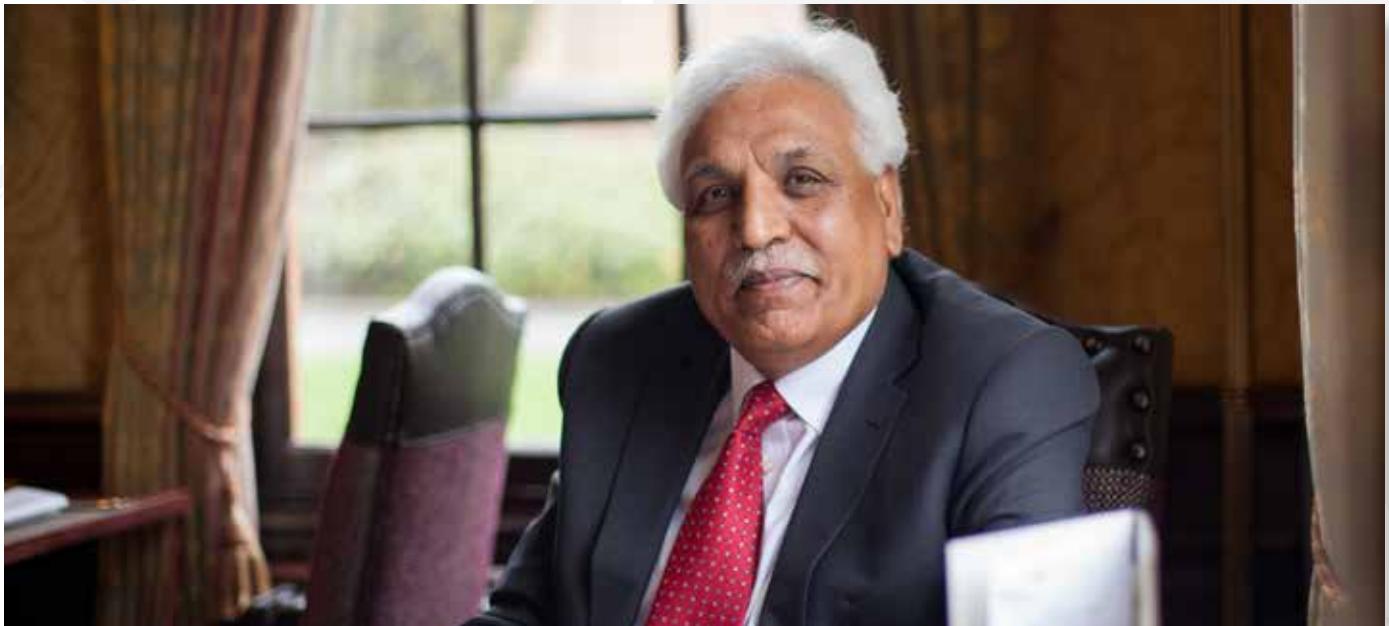
- Advanced general adult psychiatry.
- Child and adolescent psychiatry.
- Consultation liaison psychiatry.
- Forensic psychiatry.
- Older adults psychiatry.
- Learning disability

Being an academic program, we are blessed to have an entire day every week dedicated to teaching; comprised of lectures, case presentations and journal clubs. I also got the chance to learn about healthcare quality and research which enabled me to successfully implement quality improvement projects and publish the results of several studies I was involved with.

“In nothing do men more nearly approach the gods than in giving health to men”

Cicero (106 B.C. - 43 B.C.)

Looking back at this journey, I can only say that choosing to be a psychiatrist was one of the best decisions I have ever made. What we do is the greatest of privileges and the highest of honours.



Dr Afzal Javed, President-Elect of the World Psychiatric Association

Interview with Dr Afzal Javed, President-Elect of the World Psychiatric Association



By Dr Ahmed Hankir

On Saturday 15 February 2020, the World Psychiatric Association (WPA) Working Group on Medical Students, in collaboration with Qatar Medical Students' Association (QMSA), Sidra Medicine, Weill Cornell Medicine - Qatar (WCM-Q) and Qatar University (QU) held Qatar's Inaugural Medical Students' Conference on Psychiatry and Mental Health. This event was part of a series of innovative conferences led by a WPA working group on Capacity Building through Promotion of Psychiatry among Medical Students and link to WPA's upcoming 2020-2023 Action Plan¹.

The conference included a roundtable discussion on psychiatric training in different parts of the world such as the United States, the United Kingdom, Germany, France, and Qatar and hosted a plethora of guest speakers including Dr Afzal Javed (WPA President-Elect), Dr Zainab Imam (Psychiatrist in Women's Mental Health at Sidra Medicine and Medical Students Clerkship Director) and Dr Rashid Zaman Consultant Psychiatrist and Honorary Fellow at University of Cambridge². I was absolutely honoured and delighted to also receive an invitation by Dr Zainab Imam to give a talk on, 'Mental Health Stigma and its Antidote' at the conference. I remain deeply indebted and grateful to Dr Imam for the kindness and hospitality that she showed me throughout my stay in Doha.

The Qatar conference was a huge success and was attended by over 100 participants including medical students, psychiatrists, educators, researchers, and psychologists².

During a lunch break I approached Dr Javed and asked if he would be able to accept my impromptu invitation to be interviewed for *The Registrar* and, to my delight, he was able to oblige...

Ahmed: Firstly, I would like to thank you for accepting our invitation to be interviewed for *The Registrar*. Can you tell us more about your background and what your interests are?

Dr Javed: Many thanks Ahmed for inviting me to be interviewed for *The Registrar*. I believe that the Psychiatry Trainee Committee magazine is one of the most important publications from the Royal College of Psychiatrists. Regarding my professional journey, I qualified from

King Edward's Medical College in Lahore in Pakistan. I then completed post-graduate training in psychiatry at the University of Edinburgh and at Maudsley Hospital in London. I returned to Pakistan where I worked as a consultant psychiatrist for over 10 years. In the year 2000, I came back to the UK and took up a post as Consultant in Rehabilitation Psychiatry at Coventry and Warwickshire Partnership NHS Foundation Trust. I also hold teaching and research posts with the University of Warwick. I was very fortunate to serve the Royal College of Psychiatrists in different roles. I was the Associate Registrar of the College and I was also Chair of a College Division.

Ahmed: In your capacity as President-Elect of the WPA what is your ambition?

Dr Javed: Each President-Elect formulates an election-plan that needs to be delivered during their tenure as President of the WPA. I will be taking over as President from October 2020.

There are several major areas that I want to emphasise and promote during my period at the helm. The first one is to improve the image of psychiatry and psychiatrists. I believe that unfortunately as a profession, we are not enjoying the respect that we should. Linked to that is the second area of capacity-building. I'm specifically interested in promoting psychiatry among medical students and improving undergraduate and postgraduate psychiatry teaching and training. The WPA is committed to supporting countries that are struggling, through no fault of their own, with their postgraduate psychiatry teaching and training programmes. We are fortunate that our member societies from High-Income Countries (HIC) like the Royal College of Psychiatrists, the Royal Australian and New Zealand College of Psychiatrists and the American Psychiatric Association that have a lot of resources in teaching and training have pledged their support to help build capacity in Low- and Middle-Income Countries (LMIC). I want to focus on facilitating partnerships between member societies from HIC with member societies from LMIC to help improve teaching and training programmes in psychiatry. More importantly, I would be interested in conveying this message to all countries that in the design, development and delivery of their psychiatry curricula, regardless if this is at undergraduate or postgraduate levels, they have to really emphasise on basic issues such as the image of psychiatry, the importance of psychiatry in society and the interface of psychiatry with physical health.

Ahmed: What role if any can trainees play in promoting the WPA agenda?

Dr Javed: I personally feel that undergraduate teaching

in psychiatry is incredibly important since medical schools are where we can plant seeds about how thrilling and rewarding a career in psychiatry is in the fertile minds and hearts of students. As mentioned already, increasing interest in psychiatry as a career at medical school level is a priority on the WPA agenda. I believe that psychiatry trainees whether they are working in HIC or LMIC, must promote the psychiatric profession at every opportunity. They must also create these opportunities themselves. We know the Royal College of Psychiatrists Choose Psychiatry campaign has been hugely successful and psychiatry trainees played an integral role in that initiative. We would like to invite trainees to showcase any research they have conducted on recruitment and retention at WPA conferences that are held throughout the world. These events provide a platform for you to network with your counterparts in other countries and to also meet the WPA committee.

Ahmed: What advice can you give to trainees who have a dream to one day become President of the WPA?

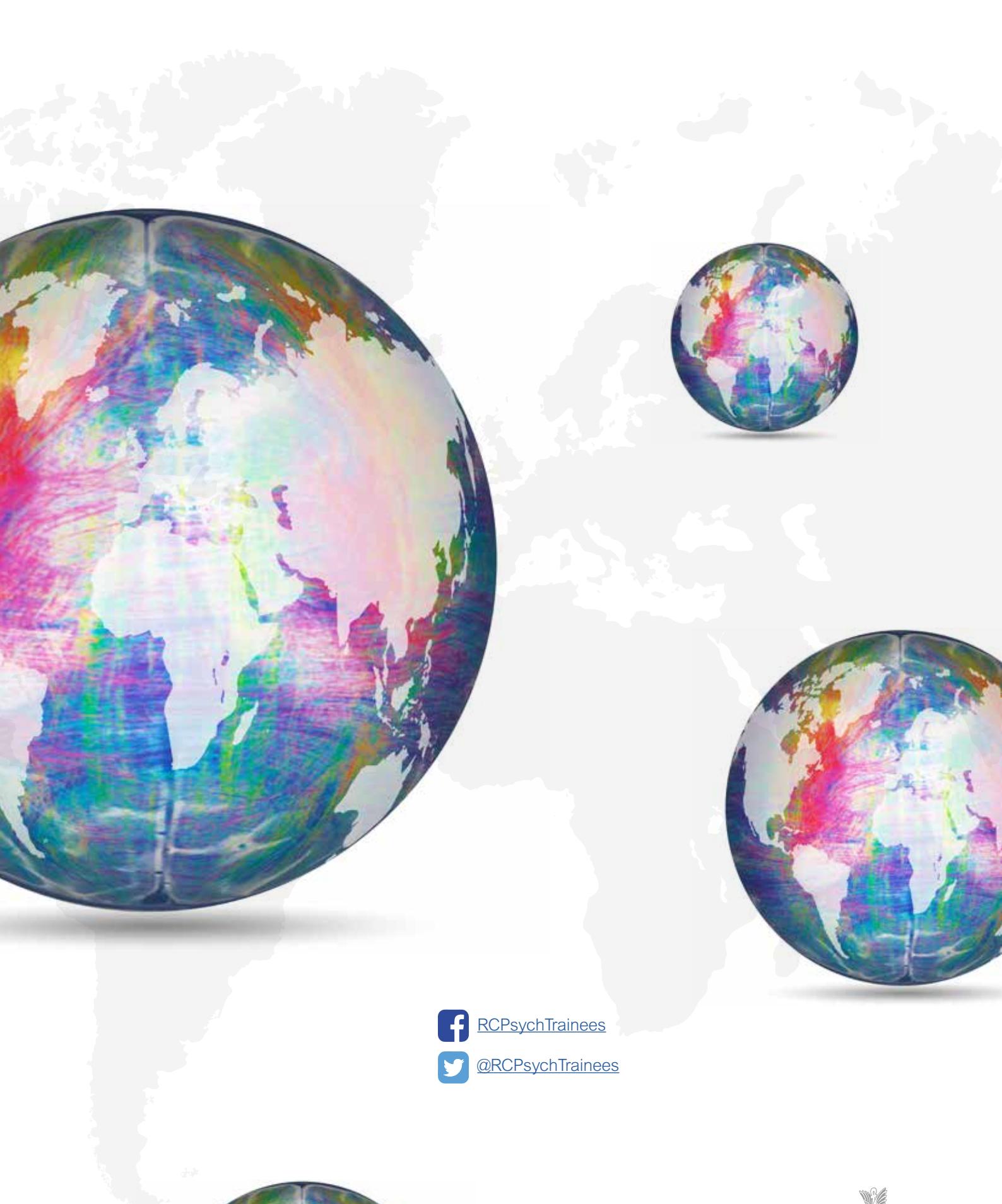
Dr Javed: My message would be if you are dedicated, if you have a vision, and if you have an important role model in your life, you can achieve anything. My role model was the first professor of psychiatry in Pakistan and that was the time when the professors were true polymaths. They were teachers, researchers, policy makers and clinicians. I was fortunate that I received training in all of these areas by my role model which certainly helped me a lot. And then of course when I arrived in the UK, I was fortunate to be trained by some of the most eminent professors of psychiatry in the world when I was in Edinburgh and London. These trailblazers and pioneers really made me feel supported and valued. They also empowered me to realize my potential. So, believe in yourself, have a vision, work hard and with integrity and identify a role model who you can turn to for support and guidance and you can realize your dreams whatever they might be.

Ahmed: Thank you again Dr Javed for accepting my invitation to be interviewed for *The Registrar*.

Dr Javed: You are very welcome Ahmed, thank you for inviting me, it was my pleasure.

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