The opinion of psychiatric residents on the training they receive

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The results of a survey carried out by the Spanish National Board for Psychiatric Training among psychiatric trainees in their third and fourth year of training are presented and discussed. The aim of the survey was to know the resident's opinion and level of satisfaction on the training they had received.

The results indicate that the majority of residents had complied with the National Program for Psychiatric Training requirements and that their level of satisfaction was fair. However a small but substantial percentage did not comply adequately with the program, particularly in relation with the training in psychotherapy, research methodology, old age psychiatry, neurology and general medicine.

Based on these results the National Board puts forward some recommendations meant for those involved in the training of psychiatrists in Spain.

Key words:
Training, education, psychiatric speciality, postgraduate

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La opinión de los residentes de psiquiatría sobre la formación que reciben

Se presentan y comentan los resultados de una encuesta llevada a cabo por la Comisión Nacional de Psiquiatría entre los MIR de psiquiatría de tercer y cuarto año. La encuesta tuvo por objeto conocer la opinión de los residentes sobre la formación que recibieron, así como el grado de satisfacción que experimentaron.

Los resultados indican que la mayoría cumplieron con los requisitos del Programa Nacional de Formación Psiquiátrica y que su grado de satisfacción fue bueno. No obstante un porcentaje pequeño pero sustancial de residentes no cumplieron el programa de forma adecuada, particularmente en relación con la formación en psicoterapia, metodología de la investigación, gerontopsiquiatría, neurología y medicina general.

Basándose en estos resultados la Comisión Nacional expone su opinión y presenta unas recomendaciones dirigidas a las partes interesadas en la formación de los residentes de psiquiatría en España.

Palabras clave:
Formación, educación, especialidad de psiquiatría, postgrado

INTRODUCTION

The National Board (NB) of psychiatry is the advisory body of the Ministry of Health and Social Policy and of Education in training material for psychiatrists in our country. Its two most important missions are the development of the national program of the specialty and the requirements for accreditation of the Teaching Units.

The NB is made up of 9 highly qualified professionals in these materials who represent the Ministry of Education, National Board of the Medical Association, the Regional Communities and scientific associations as well as two representatives of the Psychiatry Residents.

A key element for the effective functioning of the NB is knowledge regarding the impact of their recommendations on the real training of the residents. At present, the NB receives this type of information through audits conducted periodically by the Ministry of Health among the Accredited Teaching Units (ATU) (Royal Decree 127/1984), but this information has a general character and also only reaches the NB when some serious deficiency is detected. If it does not have adequate information, the NB may lose track and

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end up becoming an effective company producing useless documents. Aware of this risk, the Board has recently initiated a policy of approaching the reality through face-to-face meetings with the psychiatry tutors and also virtual meetings through the tutor web network. Both initiatives have been extremely beneficial for the exchange of opinions. Along this line of approach to reality, the NB has carried out a survey aimed at third and fourth year medical residents oriented towards knowing their opinion on the training they receive and to then use that information to improve it. The purpose of this article is to make known the results of the survey and the recommendations that the NB have proposed based on the results obtained.

MATERIAL AND METHODS

The study population includes psychiatric residents in their third and fourth year of residency in some of the Mental Health Accredited Teaching Units during the year 2008 (n=363) and according to the training program approved in 1996 by the Resolution of the State Secretary for Universities and Research of the Ministry of Education and Science, 25 April 1996.

Surveys were sent from the Subdirection of Professional Planning of the Ministry of Health and Social Policy to all of the Accredited Teaching Units for psychiatric residency training, requesting them to be distributed among the third and fourth year residents and once filled out, to return them to the Ministry. In addition, a letter was attached for the resident explaining that the "purpose of the survey is to know the current status of Residency training in Psychiatry, in order to propose measures to improve it " since "it is not reasonable to introduce changes in their training without first knowing the opinion of the residents." Those surveyed were requested to maintain their anonymity in order to facilitate their expression of critical comments.

RESULTS AND DISCUSSION

A total of 216 (60%) third and fourth year residents answered the survey. This amount of response is a serious limitation for the interpretation of the results since we do not know the characteristics of the bias caused by lack of response of 40%. However, in favor of the reliability of the results is the fact that they coincide with that which could be expected according to the opinion of the tutors of the residents we have consulted. Apart from that, the low rate of response obtained is not uncommon since this does not generally exceed 60% in surveys obtained through the mail.

One third of the residents were completing their third year of training and two thirds were completing the rest. Although residents from all of the Regional Communities answered, it was not possible to break down the results due to the insufficient size of the sample in most of them and because of the anonymous character of the survey, it has also not been possible to present the results by Teaching Units. The Communities that provided most of the responses were Catalonia (22%), Andalusia (15%), Madrid (13%) and Castilla y Leon (12%).

In order to discuss the results, we will only use the training program requirements in force during the training period of those surveyed as reference. We will not establish comparisons with other surveys because the diversity of methodologies used do not make it possible to draw valid conclusions.

Table 1 Duration of the rotations made

	mean	SD
Neurology	2.7	0.9
Medicine	1.6	1.2
Community MH Team	8.0	4.8
Outpatient clinics	8.0	3.7
Acute units	10.0	3.0
Consultation and liaison	-	-
Rehabilitation	3.3	1.7
Child/Adolescent Psychiatry	4.2	1.6
Gerontopsychiatry	1.0	1.6
Drug addictions	2.1	1.4
Elective rotations	2.9	1.7
Others	2.6	2.5

Table 2 Theoretical -practical training

In the last 12 months	Clinical sessions	Bibliographic sessions	Monographic seminars
How many did you attend?	27.6 (18.2)	12.8 (16.2)	12.1 (16.8)
In how many were you a speaker with previous supervision?	1.9 (1.9)	0.7 (1.3)	1.1 (3.1)
In how many were you a speaker without previous supervision?	1.8 (3.6)	1.6 (2.4)	1.7 (5.1)
Total cases presented	3.5 (3.7)	2.2 (2.6)	2.5 (5.7)

In the following, the questions and responses are presented one by one, followed by a brief descriptive statistical analysis. We will not provide frequency distribution tables because they take up too much space, but we discuss them when the results deviate from that required in the training program. For the same reason, the open comments collected in the survey are not presented.

How many residents are a tutor responsible for?

The mean number of residents per tutor is 6.4 (SD=3.7). The ratio is not specified in the national program, however the number obtained is close to that of 5 residents per tutor stipulated by the law (Real Decree 183/2008). However, almost 1/4 of the residents (22.3%) have declared that they share a tutor with at least 10 more residents, which seems to be clearly an inadequate ratio.

Specify in months of duration the rotations made

Table 1 indicates the duration in months of the rotations made by the residents. In general, the distribution corresponds with the recommendations of the national program. However, variability in the duration of some rotations, especially by the mental health, gerontopsychiatry and drug addiction teams has been observed. Some residents have prolonged some rotations, for example, in outpatient consultations or acute units, for up to two years, in detriment of the duration of other rotations, this breaking the overall balance of the program. The response on the duration of the rotations of the consultations and liaison could not be evaluated because these rotations in many services were performed simultaneously with the rotation of the acute units or outpatient clinics.

Is there any full time and specific dedication to theoretical teaching?

Almost all the residents (92.1%) have some time reserved for theoretical training, this ranging from zero to 55 hours per month, with a mean of 17 hours/months (SD =9.7). This result is close to the five hours a week required by the program, but with great variability since a few residents do not receive any training and others receive more than twice that required.

In table 2, some data are shown regarding the dedication to different theoretical-practical training activities in the last 12 months. The most frequent training activity is by means of the clinical session, with a mean of two sessions per month, followed by bibliographic sessions and monographic seminars, with a monthly session.

Table 3 Material resources for the training

	% Yes	Mean	SD
Do you have easy access to a library?			
How many days did you use the library in the last month?		2.9	4.3
Is there easy to access to newspaper archives?			
How many days did you use the newspaper archives in the last month?		0.9	2.2
Is it easy to access the Internet from your center?	78.2		
Is it easy to access electronic journals with the complete text?	61.6		
How many days did you use this service in the last month?		4.5	5.6

The program requires the residents to attend one clinical session weekly but the mean obtained is approximately half. Even more, the detailed analysis of the distribution of frequencies indicates that less than one-third (29%) reach the desired frequency. In regards to the frequency of other activities, the mean frequency is one every two or three weeks, although once again with great variability. The program does not mention these two activities, so that they can be considered an added value.

It is obviously that although the program does not explicitly mention it, both the clinical sessions and the seminars, especially the former, should always be performed with the active participation of the resident and with supervision prior to the presentation. This is where the system fails since the mean number of cases presented with supervision in the clinical sessions does not reach two per year, this being even lower in the remaining activities. According to the distribution of frequencies, a substantial percentage of residents did not actively participate in any of the activities (7% in clinical sessions, 22% in bibliographic sessions and 45% in the bibliographic seminars).

Table 3 shows the material resources allotted for the training of the residents. The material resources necessary are not described in the training program, however it is clear that all the residents should have easy access to a library, to a newspaper archive and to Internet. However, this need is not met, as can be seen in the table. The distribution of frequencies shows that 10% of the residents do not have access to a newspaper archive or to Internet in the place of work. Even more important is the low use of these resources: in the last month, 36% had not used the library, 74% had

not used the newspaper archive and 30% had not downloaded a single article from the network.

In regards to the general duties, the national program does not quantify them. However, in reference to those of the specialty, it states that "at least 2 and a maximum of 6 duties per month must be performed during the 4 years of training, this being consistent with the reality described by those surveyed (table 4).

Table 5 shows the type of supervision received during the duties of the specialty in each one of the years of residency. In almost every case, the supervision was performed by a staff physician, most of the times with physical presence, this percentage decreasing as the experience of the resident increased, as is to be expected by the type of progressive autonomy defended by the training program. However, it should be pointed out that the program requires supervision by the physical presence of a specialist for first year residents, a requirement that was not fulfilled in 10.3%. Although the percentage is relatively low, it is a very serious fact due to the consequences this could have for the patients and the resident per se.

The program stresses the importance of training in research and it also requires the resident to participate in research work. In the survey, it was verified that almost all the residents have participated as authors or coauthors of a publication, poster or oral communication (table 6). The mean research products per resident were 7, although almost one fourth (23.7%) has participated in more than 10 products. This is clearly excessive and reveals a distortion of the system in these cases. On the other hand, it is very satisfactory to verify that almost all had received training in research (87.5%) (most through their participation in doctorate courses) and that one out of every five were doing their doctorate thesis. However, the detailed analysis revealed that those who had not received training reached a mean scientific production similar to those who had (5.2 *vs* 7.6 products/year).

The suitability of the sites available for most of the residents to study and to rest was adequate. However, three aspects regarding work safety were clearly deficient (table 7). It is especially serious that only 9% of the residents had received training in the management of violence, although this subject is not dealt with in the national program.

Table 8 indicates the degree of satisfaction experienced by the residents regarding the performance of each one of the rotations. If we use scores equivalent to those used in the scholastic setting, most would be excellent. The maximum grade was obtained by the elective rotations chosen by the resident, as is natural, followed by rotations through the community mental health teams, outpatient consultations, acute unit and child and adolescent psychiatry. Geriatric psychiatry and rehabilitation are the two specific rotations that obtained the worse grade, together with those of neurology and medicine. The highest percentage of the grade of failed (%<5) also corresponded to these four rotations.

Table 4 Frequency of the duties

	Mean	SD
How many months of general duties have you made?	6.8	8.4
What was the average of general duties/month?		2.1
Mean psychiatric duties per month in the last 12 months	5.7	7.1

Table 5 Supervision received during the duties

	% as R1	% as R2	% as R3	% as R4
Without supervision	0	0	1	4.3
With "older" resident	1	1	1	0
With localized staff	9.3	23.7	27.6	31.3
With staff present	89.8	75.4	70.5	64.3

Table 6 Training in research methodology

	% Yes
Have you received training in research methodology?	87.5
Have you begun to do your doctorate thesis?	19.0
Have you participated in any research during your residency?	80.1

Table 7 Comfort and safety in the worksites

	% Yes
Do you have an adequate place to study in your worksite?	64.4
Do you have an adequate room during the duties?	76.9
Do the consultation rooms have resources to cope with a situation of risk?	34.3
Does the hospital perform emergency drills?	13.4
Do the residents receive practical training in the management of violence?	9.3

Table 9 shows the grades of satisfactions experienced by the residents in other training aspects. Most of the grades corresponded to passed. The worst grades were obtained in the general duties and supervision of psychotherapy and the only two excellent grades were cornered by the tutor and clinical supervision. The perception of work safety and research also had low approval. Supervision of psychotherapy, the general duties and research received the highest percentages.

The survey concluded requesting open comments. A total of 70% of those surveyed gave their opinion on the deficiencies in the training received. Most of the complaints focused on the lack of training in psychotherapy (41%), research (18%), duties (10%), insufficient clinical supervision (8%) and in that priority was given to health care over training (6.5%).

Table 8 Degree of satisfactions experienced during the rotations (score between 0 and 10)

	Mean	SD	% <5
Neurology	6.7	1.9	10.3
Medicine	6.4	2.2	16.2
Community MH Team	7.9	1.7	1.8
Outpatient clinics	7.8	1.6	3.7
Acute unit	7.8	1.6	3.5
Consultation and liaison	7.2	1.9	4.1
Rehabilitation	6.7	2.1	6.9
Child/Adolescent Psychiatry	7.8	1.6	4.4
Gerontopsychiatry	6.2	3.5	22.9
Drug addictions	7.3	2.2	7.4
Elective rotation	8.7	1.7	1.8
Others	7.1	2.2	11.0

Table 9 Grade of satisfaction experienced in relationship with other teaching aspects (score between 0 and 10)

	Mean	SD	%<5
Tutor	7.3	2.1	11.0
Clinical supervision	7.1	1.6	6.7
Psychotherapy supervision	4.7	2.8	38.9
Theoretical -practical training	6.8	1.9	10.5
Pedagogic material	6.1	2.2	17.7
General duties	4.4	2.4	45.0
Psychiatry duties	6.9	1.9	9.1
Research	5.1	2.4	33.7
Comfort	6.6	2.1	12.4
Safety	5.8	2.3	20.1

COMMENTS AND RECOMMENDATIONS

- It must be remembered that the law requires the tutor to be the same during the entire training period and to be in charge of a maximum of five residents (Royal Decree 183/2008, art. 10.3). In order to do this in a reasonable way, it is essential for the tutor to be recognized and to be given incentives and the resources needed to carry out his/her work, including the necessary time of dedication for one's own formation as a teacher and for the tutoring practice (ibid, arts. 10.4 and 12).
- Regarding the rotations, the results of the survey revealed that the national program is fulfilled relatively well on the whole, but that it has excessive variability. Some residents rotate through some health care areas for more time than that foreseen in the program, in detriment to the time dedicated to other rotations. This is surely because of care type reasons, more than teaching ones. It is necessary for the rotation times required in the national program to be respected. The increase or reduction in the rotation time disrupts the overall training balance that the generalist psychiatrist should receive.
- Similarly, in some theoretical-practical activities, some residents, in a significant percentage, receive less training than proposed in the program, research training standing out in this sense. Participation in more than 10 research studies, as is the case of many residents, aims more to achieve a good curriculum to be able to compete better in the work market than to obtain good scientific training. Research training does not consist in participating in many projects. One single, well-supervised project complemented with bibliographic seminars can provide a complete view of the basic principles of the methodology.
- The system fails in regards to availability of material resources for training. Nowadays, it cannot be conceived that some residents, however small the percentage, do not have access to a newspaper archive or to Internet. The low use made by the residents of the existing resources must also be pointed out. This reveals the lack of capacity of the system to stimulate them to actively participate in their training.
- Specific duties for the specialty, in terms of frequency and quality of the supervision, are complied with in general as required by the program, although a certain percentage of first year residents declare they have not received adequate supervision. It is obligatory for the first year residents to have physically present supervision

by a specialist present during their duties (Royal Decree 183/2008, art.14.3). A very high percentage of residents are unsatisfied with the experience of the general duties. It is not possible to know why based on the open comments.

- The residents are moderately satisfied with the rotations performed except for those of gerontopsychiatry and the rotations through medicine and neurology. The open comments provided indicate they are dissatisfied because of insufficient planning and organizations of these two rotations. Close collaboration between the tutors of psychiatry, medicine and neurology could help to clearly establish the objectives and the program of these rotations. It is likely that the lack of satisfaction with the rotations through gerontopsychiatry could be related with insufficient development of this service in most of the accredited teaching units.
- Lack of training in psychotherapy is a serious problem. In the open comments, mention is made of the need for quality supervision. The scarcity of well-trained professionals who have sufficient time to cover this need is probably one of the reasons. The health care pressure which the residents undergo may be another. Capacity to provide psychotherapy is one of the most specific competences of the specialty. This subject was widely dealt with in the new program approved last year (Order SCO/2616/2008, BOE 224).
- Lack of training in the management of violence and the adequacy of the offices to cope with an at risk situation is a serious deficiency that should be taken seriously, even though the specialty does not mention it in the new program.

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