

continue to do so. For this expansion to be successful further investigation into its effectiveness is warranted.

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Teaching undergraduate psychiatry in a forensic setting

Typically, medical students do not learn about psychiatry in forensic settings. Depending on their interests and their medical school, they might have access to special study modules or elective placements in their final year. We introduced undergraduate psychiatry placements at our regional forensic service in New Zealand and surveyed the experiences and attitudes of our students over the past 2 years. The placement includes experience of medium-secure in-patients, community, prison and court liaison services.

McGauley & Campbell¹ asked whether medical students needed to know anything about forensic psychiatry and concluded that forensic psychiatry taught students about managing chronic illness, working with complex patients, understanding stigma and security, learning about personal and organisation dynamics and experiencing multidisciplinary, cross-disciplinary and multi-agency working. Such issues are relevant to all psychiatric specialties and some areas of medicine.

The University of Otago Medical School, Dunedin, was the first to be established in New Zealand. There are about 270 students each year. Students study psychological medicine throughout the 2nd year, and 8-week attachments, divided between two different areas of psychiatry, are compulsory in the 4th year. Students attend placements as part of the clinical team and complete logbooks of experiences, including team working and ethics. They see patients and learn about the assessment, formulation and management of common mental health problems. They regroup for weekly medical school teaching and undertake an examination with written and practical components.

We designed an online survey, which the medical school emailed to our 15 students who had spent their psychiatry placement with our forensic service; 73% (11 students) responded. They were asked about the expectations and experiences they had had, the disorders they had learnt about, what they had enjoyed and what could have been improved.

Interestingly, 27% were anxious about starting their placement. Most students thought that they would be learning mainly about 'legal issues' and seeing patients in prison. Some had 'no idea' what to expect. All respondents gained experience of seeing patients with schizophrenia, bipolar disorder, drug and alcohol problems and the problems associated with psychological trauma and head injury. Over

70% also gained experience of seeing patients with personality disorders. Depressive and anxiety disorders were less commonly encountered, with around half of students gaining experience of these. We learnt that about 27% of respondents felt unsafe at some point during their placement and subsequently introduced a first-day security and safety induction and distributed a leaflet explaining the nature of forensic services and the placement, which we were told was useful.

All students were positive and stated that they had enjoyed their placements. Over 70% rated the placement as 'excellent'. They appreciated seeing patients in a variety of settings which included in-patient, community, prison and court, and gained experience of a variety of mental health problems. Some students remarked that the placement was one of the best they had done in their undergraduate training to date. Forensic settings can therefore provide useful and enjoyable experiences to students as they learn about psychiatry as undergraduates.

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Recruitment into psychiatry is working, but we are responsible for maintaining the momentum

It is no secret that psychiatry has always struggled to recruit adequate numbers of doctors. This has led to the Royal College of Psychiatrists launching its Recruitment Strategy, implemented by a recruitment team. Their targets are to increase recruitment to core psychiatric training, achieving a 50% increase in applications and a 95% fill rate by the end of their 5-year campaign. It is therefore most encouraging to learn that those foundation year (FY) doctors who are exposed to psychiatric placements are almost ten times more likely to embark on a career in the specialty. *BMJ Careers* reports¹ that 15% of those FY2 doctors who undertook psychiatry placements applied for core psychiatry training, as compared with a mere 1.8% of those with no psychiatry exposure during their Foundation Programme. At last, a reason for quiet optimism, perhaps.

However, if we are to succeed in helping the College achieve its targets, it is clear that supervising clinicians have an important role to play. Archdall *et al*'s qualitative study assessing medical students' perspectives of psychiatry post-attachment,² makes it patently clear that positive role models are a key factor in influencing eventual career choice. Respondents valued enthusiasm, eagerness to teach and motivation in those they were attached to as the most important qualities. It is highly likely that similar factors come into play with respect to influencing foundation doctors in choosing to pursue a career in psychiatry. Therefore, it is critical that those of us who are fortunate enough to supervise students and recently qualified doctors are fully conscious of our powers to positively influence recruitment. With great power comes great responsibility, as the saying goes, so the future of our specialty lies in our own hands.

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Why choose psychiatry? Report on a qualitative workshop

As trainees, we thought that examining the views of trainees who have already chosen psychiatry might add to our understanding of the factors involved in career choice.

In November 2009, the London Deanery School of Psychiatry hosted its annual trainee conference themed 'Recruitment – Everybody's Business'. There we facilitated two identical, optional qualitative workshops entitled 'Choosing psychiatry as a career – influencing the next generation'. Each workshop was attended by 30 individuals, and facilitated by 5 senior trainees and 4 medical students who took verbatim notes. Framing questions were used to identify key themes regarding positive and negative influences on career choice.

Of the 184 delegates, 86 (47%) were male and 106 (58%) reported Black and minority ethnic backgrounds. Two of us (M.P. and K.F.) used thematic coding until saturation of themes emerged. We report these themes briefly here.

Participants described the doctor–patient relationship, the human narrative ('psychiatry is about stories, rather than abstract algorithms'), and the rapidly evolving nature of psychiatry ('you can do things which are ground-breaking') as attractors to the field. They emphasised the importance of conveying the high work satisfaction and good work–life balance, job flexibility, and 'colourful colleagues [who make it] fun' to medical students.

Factors that nearly discouraged trainees from a career in psychiatry included stigma and negative attitudes towards the profession from colleagues. Several trainees described unhelpful experiences during their foundation years: being 'ignored by a consultant surgeon after disclosing an interest in psychiatry', and how physician colleagues 'did not have a positive thing to say about the specialty'. Medical student participants as a subgroup also commented on the effect of negative attitudes from other professionals ('boring job', being seen as 'less of a doctor' and 'becoming mad as a psychiatrist'). Such inter-professional stigma towards psychiatry has been reported to negatively influence choice of psychiatry as a career.^{1,2} Intra-professional stigma and 'negative attitudes and behaviour' were observed among teachers, who were reportedly 'a bit embarrassed about being psychiatrists'. A further theme was the lack of professional confidence and evident role uncertainty among psychiatrists: 'Psychiatrists have big issues with the specialty they've chosen – we don't feel confident we're as valuable as other medical specialties; we're not sure what our role is and what we contribute'.

When trainee psychiatrists were asked what they could do individually and collectively to inspire the next generation,

the main emphasis was on high-quality teaching and clinical placements, making time for experiential teaching, and helping students to feel part of the team. The importance of positive modelling by psychiatrists^{3,4} was also noted, for example, being 'passionate about psychiatry'.

Changes in attitude and perception, both within and without psychiatry, along with improved student placements, role modelling and teaching quality must occur if we are to address low recruitment and, in the words of one of the participants, 'make the specialty something to aspire to, rather than something into which people drift'.

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What about old age psychiatry?

We welcome the article by Oakley *et al*.¹ creating a robust training programme more focused on developing medical expertise will go a long way to addressing the identity crisis currently ravaging psychiatry. However, we were concerned about the proposed structure of postgraduate training with regard to the dearth of old age psychiatry experience. Currently, it is possible to undertake one, and in some cases two, 6-month old age placements at any point during core training. The proposed training reduces this significantly to one 4-month placement as a CT1. All other subspecialties are represented by 6-month placements between CT2 and CT4. It is unclear why old age psychiatry has been excluded from this. Although old age experience at an early stage in training is important, this can only serve as a basic introduction to the specialty and will not allow for the development of expertise and excellence as emphasised in the Tooke report.²

It seems perverse that the authors recommend increasing the total duration of training while reducing the time spent in old age psychiatry. To exclude old age psychiatry from CT2–4 placements suggests non-parity with other psychiatric specialties. We fear this may harm recruitment to the field, as it becomes a distant memory by the time choices for specialisation are made as a CT4. It neglects to tackle the situation of trainees who are undecided about old age psychiatry and would benefit from further experience to aid their decision, or those who have, early on, settled on a career