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Training matters

Serendipity in psychiatric sub-specialty selection and training

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The word serendipity has its origins in a fairy-tale about 'The Three Princes of Serendip', the latter being the former name for Ceylon. The heroes of this fairy-tale were always making discoveries, by accident and sagacity, of things they were not in search of. The earliest use of this term was by Horace Walpole, the essayist, who coined it in a letter of 1754. Later, he wrote a little fairy comedy on this theme, which was produced successfully at the Haymarket Theatre, London. The term means, therefore, the gift of being able to make delightful discoveries by pure accident and this is why it is used sometimes as the name for an antique shop or a second-hand clothes store. It is likely that most people could give examples of serendipitous incidents in their lives and the purpose of invoking the concept of serendipity in relation to sub-specialty selection by trainees is concerned with the possibility that chance can be a major determinant of outcome in this process. This issue is related to wider concern that the optimum methods for the well-informed recruitment of trainees into the sub-specialties and special interest areas in psychiatry have not yet been organised satisfactorily.

In this context, the aims of this paper are: to examine the ways in which sub-specialty selection are made currently by psychiatric trainees, as part of their long-term career plans, and to comment on any associated problems; to explore the role of chance, in this process, during psychiatric training; to consider the consequences of serendipity for individual trainees, for the sub-specialties and for psychiatry as a whole; and finally, to make some recommendations.

This paper will not address wider issues about resource allocation for the sub-specialties or manpower planning concerned with how many and what types of psychiatrists should be produced to meet future needs and service demands. Further, detailed consideration is not given to the implications for career pathways of new training plans for the amalgamation of registrar and senior registrar grades. These do not appear to be well-suited to the current structure of training in psychiatry, and seem likely to reduce flexibility in training and to make it difficult for trainees to change their minds.

In considering questions about sub-specialty career selection, I will be drawing upon reasonably wide experience of general and specialist training in psychiatry. This includes organising a large rotational training scheme, and being a regional specialty tutor and co-ordinator of a higher training scheme in child and adolescent psychiatry. I have participated in the approval exercise and I have been a member of the Joint Committee on Higher Psychiatric Training and chairman of its sub-committee in child and adolescent psychiatry (CAPSAC). Finally, as a consultant, I have supervised the work of over 80 registrars and senior registrars. Naturally, my experience of issues concerned with sub-specialty selection is derived mainly from child and adolescent psychiatry and most of the illustrative examples will be drawn from this field.

Sub-specialisation is psychiatry

The current pattern of sub-specialisation in psychiatry is a relatively recent development. Even 30 years ago, when I entered psychiatry, it was possible to move quite easily across what are now regarded as sub-specialty boundaries. This enabled me to explore different areas of practice and to end successfully in the emerging sub-specialty of adolescent psychiatry. The growing formalisation of psychiatric training, however, particularly in the sub-specialties, has restricted such ease of movement. Further, while the refinement of the identities and the codification of the borders of the sub-specialties has led to the upgrading of training, enhancement of expertise and competence of practitioners and improvement in the quality of service delivery, there are negative aspects of sub-specialisation.

In my clinical practice, I am aware frequently of the adverse effects of the segregation from mainstream psychiatry of psychiatric services for infants, children and adolescents and the way it can lead to the fragmentation of care and the weakening of a comprehensive approach. Similarly, the increasingly

separate clinical and academic lives led by child psychiatrists and practitioners in other branches of psychiatry illustrates the way sub-specialisation can fragment the profession as a whole. When I visit developing countries, with ostensibly less advanced psychiatric services, I often cast an envious eye at psychiatrists who are still practising within a generalist tradition.

Despite certain inherent disadvantages, however, the trend towards sub-specialisation appears to be inevitable and increasing numbers of psychiatrists are focusing their practice on a limited field. This trend is likely to continue, in conjunction with advances in knowledge and technology. It will lead to the delineation of new academic and practice sub-specialties, generating difficult questions about their recognition, status and credentials. In the immediate future, the integrity of general psychiatry as the core specialty is unlikely to be threatened and it will continue to serve as the basis for sub-specialisation, although the current status of general internal medicine serves as a reminder of likely future developments.

This paper is concerned principally with entry into the main sub-specialties of the present day, namely general adult psychiatry, child and adolescent psychiatry, forensic psychiatry, mental handicap, psychotherapy and the psychiatry of old age. In addition, I do not want to overlook the fields currently designated as subjects of special interest or special responsibility in consultant posts. These include substance misuse, consultation/liaison, social and community psychiatry, rehabilitation and administrative psychiatry. In all these areas, there is the further option of planning academic or practice careers. In the future, the list of sub-specialties is likely to be extended progressively to include, for example, psychiatric traumatology, family therapy, neuro-behavioural psychiatry and psychiatric molecular genetics. Inevitably, this development will raise fresh questions about the nature of education in psychiatry and the optimal pattern of training.

Pre-psychiatric determinants of sub-specialty selection

Before considering events after entering into psychiatry, a number preceding influences need to be borne in mind.

(a) *Individual factors*

Newly-qualified doctors face a bewildering choice of careers and a wide range of factors derived from the individual trainee's personality, life experiences and medical training, are likely to be influential in determining the decision to enter psychiatry. These are also going to be important in determining the most appealing models of mental illness, preferences for particular patient populations, and choices about approaches to service delivery and professional life styles.

(b) *Influences during undergraduate, pre-registration and general professional training (at SHO level)*

Some doctors may have established quite enduring ideas about their first choice sub-specialty career options, even before embarking on psychiatric training. While in medical school, experience of psychiatric specialties is likely to be very limited and insufficient for informed decisions about long-term career choice. Nevertheless, it is quite common for students to be allocated to specialty units as their principal clinical exposure to psychiatry. In this way, the experience of some aspect of psychiatric practice or of a particular model of psychiatry may have a formative influence, of a positive or negative kind. A recent elective student in my department, for example, was already set on a career in child psychiatry before completing clinical training.

Similarly, post-qualification experience in non-psychiatric medical specialties, at pre-registration or senior house officer level, may have an important influence. For example, house jobs in paediatrics or obstetrics and gynaecology may foster an interest in working with the psychological problems of children and families.

Finally, research experience, undertaken as part of an intercalated degree or for a PhD before entering clinical training, in areas such as psychopharmacology, neuroscience, and molecular genetics or experimental psychology may be important in establishing long-standing interests.

The role of chance during psychiatric training

It is evident, therefore, that the hand of chance may permeate the process of career selection in various ways before entering psychiatry. I would now like to consider its specific effect during psychiatric training.

(a) *Rotational training scheme in psychiatry*

College requirements for the approval of general professional training schemes are clear and, without doubt, the Central Approval Panel has achieved a great deal in maintaining high standards of training nationally. In organising a trainee's rotation, consideration has to be given to the individual's previous experience, special needs and interests. Sub-specialisation has already had considerable influence on the structure of training programmes. To receive full approval, a scheme must provide not only broad experience in general psychiatry, but also substantial

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experience in at least four of nine sub-specialties or special interest topics. Inevitably, however, difficulties arise, due to the insufficient number of posts or problems about their deployment, in enabling all trainees to have experience in, or even a preview of, the principal sub-specialties. Many trainees, for example, do not have sufficient experience of working with children or adolescents to make an informed choice about their careers, and I suspect that this applies equally in other sub-specialties, particularly in mental handicap and the psychiatry of old age. Inevitably, disputes tend to arise about which should be the core and the optional rotations. However, I appreciate all too well the difficulties facing psychiatric tutors in balancing the competing demands of training, the individual requirements of trainees, service delivery and continuity of patient care. In this respect, the growth of large, relatively inflexible rotational training schemes and of the gradual loss of posts outside them has reduced the scope for "birds passage", seeking brief exposure to different sub-specialties for preview purposes.

(b) *Chance experiences in training*

Within rotational training there is ample scope for chance experiences. Allocation to a particular training placement, whether or not it was initially desired, may be instrumental in changing the direction of career orientation. I can recall many registrars who discovered, during what was envisaged as a routine placement to get obligatory experience with children, an unexpected realisation of the fascination and rewards of working with pre-adult forms of psychiatric disorder. Even the allocation of particular cases may be influential in this way. Similarly, the approach to clinical practice and the professional lifestyle of a particular trainer or supervisor may have a powerful effect, and I have observed many trainees "discover" their predilection for particular sub-specialties like this. Personal inspiration derived from a book, scientific paper or lecture, or generated by the process of finding out for oneself about a particular conceptual framework and unravelling its implications may serve to fashion long-standing interests. In this respect, I can recall registrars who committed themselves to work with the mentally handicapped, after realising the extent of the intellectual challenge of research on the aetiology of handicap.

(c) *Chance and opportunism in job selection*

Outstanding trainees with well-defined career plans, one or two publications and possibly a Master's degree, are unlikely to find difficulty in obtaining appropriate sub-specialty training posts. For others, however, there may be problems. Pressures to progress to higher training and for job security are such that some registrars, having obtained the MRCPsych and completed more than three or four years of training, find themselves obliged to consider moving in any one of a number of directions, depending largely upon job availability. This situation may be complicated further by pressures to remain in a particular part of the country in order to fit in with family circumstances. This is still a special problem for married women, who may be more influenced by the availability of part-time higher training posts than by the sub-specialty. An extreme example of such predicaments was provided by one female married registrar, for whom I wrote consecutive references supporting applications for higher training in general adult psychiatry, psychotherapy and child and adolescent psychiatry, as well as a bid for a part-time higher training post. Ultimately, entry to child and adolescent psychiatry was successful, but, by this time it was difficult to decide whether the prime movers were conviction or expediency.

Negative consequences of chance as career choice determinant

When serendipity operates in a true sense and trainees discover successfully a sub-specialty or special interest field which is gratifying clinically and academically all is well. But the process may work in reverse, with negative consequences. These can be considered from several viewpoints.

(a) *Individual careers*

For an individual trainee, the pattern of rotation may leave no opportunity to preview particular sub-specialties. Alternatively, for various local reasons, a particular placement may be unappealing practically and theoretically. I have known this to be due, for example, to the absence of an influential consultant, or to the idiosyncratic and unrepresentative approach of a particular clinical unit. In child and adolescent psychiatry, where a wide range of service delivery models are in operation, exposure to the predominant use of single approaches such as family therapy or the therapeutic community, may generate an adverse response to the sub-specialty as a whole, without an opportunity to rectify the perception in an alternative placement.

(b) *The sub-specialties*

It is impossible to gauge the impact on the various sub-specialties of the opportunistic espousal of a special interest. In most cases, it probably works well and potentially adverse effects are likely to be mitigated in several ways. These are facilitated by the capacity of psychiatrists to function in a "general purpose" fashion, by the room for manoeuvre in

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most sub-specialties to practice in diverse ways and by the scope to develop personally gratifying expertise, even if it lies outside mainstream practice for the sub-specialty, in clinical and academic terms. Nevertheless, such consequences are not necessarily in the best interests of the sub-specialty, especially at a time when the mounting pressures of cost-containment demand the highest efficiency and effectiveness in psychiatric care delivery. In this context, I have known a number of child and adolescent psychiatrists whose mediocre contribution to their subject reflected disinterest and disappointment with their career choices, at a time when, unfortunately, it was too late to change direction.

(c) *Psychiatry as a whole*

It is essential not to overlook the implications for psychiatry as a whole of the failure to recruit the most well-suited trainees for careers in the various sub-specialties.

Certain fields may be avoided by trainees unless special action is taken to organise both training and preview placements and to provide up-to-date and detailed information about the career prospects. This applies particularly in the "shortage specialties" of psychiatry of old age and mental handicap, in both of which the number of consultant post tends to outstrip the number of adequately trained and motivated doctors. Poor recruitment of strongly motivated, high calibre trainees into these fields has serious consequences. Not only is work with these patient populations urgently needed, but it can be highly rewarding personally in clinical and academic terms.

Recruitment into academic sub-specialty posts is often disappointing. This is due to a variety of factors, including the limited availability of senior posts, but in this paper I want to focus particularly on the problems of recruitment into research, which is an issue of crucial importance to the future of psychiatry as a clinical science. Psychiatry is a high practice, even technique, orientated specialty. Although there has been substantial growth in scientific research, psychiatric science remains relatively primitive, and entry into this field of work is poor. This is particularly evident in child and adolescent psychiatry, where, despite both the requirements and the realistic encouragement of the Joint Committee on Higher Psychiatric Training, especially by taking a broad view of what constitutes research, many senior registrars remain ambivalent about research and manage to slip through the training years with little or no research achievement. Often the justification given is the need to acquire additional training in treatment techniques, such as family therapy or child psychotherapy. One consequence is that senior registrars can become consultants with mixed feelings about research, and with a tendency to favour similarly practice-orientated candidates in trainee selection. If this occurs the consequences are serious for child and adolescent psychiatry, the adverse effects being reflected in the limited research output in this field. More widely, inadequate recruitment of outstanding trainees with basic neuroscience research skills is reflected in the paucity of "laboratory" research in neurobiology and psychopharmacology. At present, few academic departments have an established track record in this aspect of research.

Recommendations

Serendipity pervades many aspects of professional career development. While chance and the current *ad hoc* arrangements for sub-specialty choice may generate workable, life-long careers for many psychiatrists, I believe that the present position is far from satisfactory and that problems will become more pronounced as the trend for sub-specialisation accelerates. Although it is essential to retain scope for individual freedom of choice in career selection, and it would be inappropriate to adopt the model of those countries where trainees are simply allocated to sub-specialties, more systematic planning for sub-specialty entry and the appropriate matching of training programmes to the needs of trainees is required. I would like to conclude, therefore, with a number of recommendations, directed at present trainees, at psychiatric tutors and at the relevant committees and groups in the College.

(a) *Vigorous recruitment into psychiatry*

The first recommendation concerns the necessity for vigorous recruitment into the specialty of psychiatry, where there is a need for both more trainees as well as trainees of the highest calibre. Current recruitment, which begins with undergraduate grounding in the subject, often appears to lack vigour, even though competition for entry into the specialty is not uniformly strong in all training centres. Further, in relation to the particular theme of this paper, there is scope for much more active and enthusiastic promotion of recruitment of trainees likely to be destined for particular sub-specialties. While psychiatry remains a relatively low-profile medical specialty and its survival is under threat, attention to these issues is going to be critical.

(b) *Improved presentation of the sub-specialties*

More vigorous "marketing" is needed of the clinical and academic scope and the career attractions and opportunities of the various sub-specialties and special interest subjects. This is called for at both undergraduate and postgraduate levels.

Sub-specialty promotion at College level, particularly by the sub-specialist Sections, groups and Special Interest Groups, is essential, as a corrective to the inevitably limited, even parochial, view of the different fields that trainees in any one geographical area are likely to obtain.

(c) *Representation of sub-specialties at trainee selection interviews*

While it is imperative that only those doctors who are suitable for training in general psychiatry are selected as trainees, there is scope, at the time of selection, for active consideration to be given to the identification of prospective entrants to the sub-specialties. To achieve this, SHO and registrar selection committees should include routinely representatives of the main sub-specialties so that their particular requirements can be expressed and a balanced intake obtained.

(d) *Modifications during rotational training*

Experience during the period of general professional training in psychiatry is critical for sub-specialisation. While the concept of "rotation" is now inherent in current training, a number of steps still need to be taken to correct deficiencies.

(i) There is a continuing requirement for increased numbers of designated training posts, coupled with flexibility in the planning of individual training programmes, to allow all trainees to have sufficient preview experience of the principal sub-specialties so that well-informed decisions can be made about career choices. This should apply to those who have both decided to commit themselves to a sub-specialty, as well as to those who wish to preview the various sub-specialties with an open mind.

(ii) In addition to the full-time rotational placements, offering experience in treating patients, there should be readily available opportunities for brief observational visits and secondments in a range of sub-specialties. It is important that these elective opportunities should include visits to centres of excellence or special interest outside the local training scheme, so that the broadest possible view can be obtained.

(iii) In addition to encouraging entry into academic posts, it is essential to promote active recruitment into formal research, both to advance the scientific basis of the specialty and to prepare future practitioners for a professional lifetime of rapid scientific growth. This needs to be an integral part of general professional training and not postponed to the sub-specialty training period. It is important to note that it is already possible for trainees to obtain approval as higher training, periods of time spent on full-time research after completing the MRCPsych. It should be an established expectation of training that, in addition to obtaining experience in conducting empirical research and data collection all psychiatrists should be equipped with the skills necessary to evaluate research and to incorporate research findings into their clinical practice.

(iv) Trainees should be encouraged to be mobile in their pursuit of higher sub-specialty training that is most compatible to their interests and needs.

(v) Guidance in career planning needs to be expanded and undertaken systematically with all trainees, to help them find solutions to their career problems and to choose subspecialties that are right for them. Although this would increase the burden on psychiatric tutors it could be achieved successfully in conjunction with specialty tutors and academic staff in the various sub-specialties.

(vi) *Modifications during higher training*

Finally, once entry has taken place into sub-specialty higher training, trainees should be encouraged to take an active approach in the construction of the training programme and, in particular, to be alert to the necessity to take a wider view of their chosen sub-specialty than is provided locally. All higher training schemes have different strengths and weaknesses and it should not be necessary for senior registrars to adopt a resigned approach to local limitations in education and training provisions.

Conclusions

This is a time of rapid change in psychiatry, with increasing emphasis on broad-based education and sub-specialist training, coupled with mounting cost-containment pressures. In this context, I have reviewed some inadequacies in current provisions for sub-specialty selection by trainees and outlined some proposals for the future. I fear that there has been, and still is, a substantial element of *laissez-faire* in this process, and considerable reliance on the benefits of serendipity. While the latter is an attractive proposition, it has to be recalled that the term was spawned by a fairy tale. Changes need to be initiated at many levels, but I would encourage current trainees to accept a large part of the responsibility for innovation.