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opinion & debate

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Specialist registrar training: at the crossroads (again)†

Great improvements have taken place within higher training in psychiatry, influenced by the Calman report on specialist training (Department of Health, 1993) and the publication by the Royal College of Psychiatrists (2004) of its competency-based curriculum for specialist training. Alongside these developments have been huge changes in the way that psychiatric services are configured and increased difficulties in recruiting consultant staff (O'Connor & Vize, 2003). We believe a gap has arisen between higher training and the real-world needs of psychiatric services, which needs to be tackled. These concerns are not new (Deahl & Turner, 1998) but the problems in recruitment mean that an urgent review of higher training is necessary.

Background

For trainees 'becoming a consultant' is seen as both exciting and daunting. Anecdotally, specialist registrars (SpRs) are finding the career jump from SpR to consultant to be a large one; contributory factors are the shortened training period and the perceived pressures on consultants particularly in general adult psychiatry. We know that SpRs describe the transition to a consultant post as dramatic (Houghton *et al*, 2002) and the interest in mentorship schemes has been in part a response to this (Dean, 2003). In the West Midlands in order to assess the potential need for a proposed mentorship scheme, one of the authors (N.B.) surveyed all newly appointed consultants and final-year SpRs in the West Midlands. Forty-one replies were received. When respondents were canvassed about the main areas where they felt there was a need for continuing guidance and mentorship there were seven areas that were highlighted; some were in the anticipated spheres of managerial knowledge and skill but three were dealing with areas of clinical work: managing a clinical team; tackling workload; and specific issues in dealing with clinical problems. It is likely that the implementation of *Modernising Medical Careers* will result in the combination of senior house officer (SHO) and SpR grades (Four UK Health Departments, 2004) and the emergence at 5 years of a consultant who may require continuing supervision rather than mentorship.

With the increasing emphasis on shorter training, a fundamental rethink is necessary about the style and content of higher training in psychiatry. We outline below some of the issues that have come to the forefront in the West Midlands region and make some suggestions on how higher training might develop.

What are the issues?

First, the short duration of training and the need to focus on outcomes means that to achieve a credible portfolio of learning and experience, programme directors and trainees may need to set out a clear pathway throughout higher training from the start rather than work on a year-by-year basis. This approach, although appearing rigid, will retain some flexibility but importantly will contain greater continuity of learning and development and lends itself to a more robust, valid and reliable assessment process.

Second, there needs to be a re-evaluation of the clinical component of training which may sometimes appear to be a minor part of higher training. In psychiatry 40% of higher training time is taken up with the research day and special interest sessions. The realities of day-to-day working for consultants are at least a 5-day-per-week responsibility for organising a response to clinical needs; this includes: prioritising; delegating; direct hands-on work and so on. There is no option to walk away from these responsibilities. This experience is not currently part of SpR training. Maybe the third year of higher training could be organised in such a way as to allow this experience, which may mean giving up special interest sessions. A 3-month locum post frequently exposes SpRs to the reality of a consultant's workload, however not all SpRs can be guaranteed a locum post, and some locum consultant posts, particularly if they are the result of a long-term vacancy, might not provide a suitable training experience. Is there some way of building such experience into the final year of SpR training, but with clinical and educational supervision built into the arrangement?

Third, non-clinical competencies need to be considered. The future of the research day must be in doubt; it is unclear what benefits it brings to trainees (Vassilas *et al*, 2002), and other specialties do not have research days. If the needs of consultants are considered, few (rightly or wrongly) will be active researchers, all will require audit and critical evaluation skills. This is already covered and assessed at basic training level. Increasingly, trainees are pursuing formal training in teaching and management and these are being seen as core competencies. Thus, should 20% of training time be taken for such questionable outcome(s)?

Fourth, the organisation of training itself must be considered. Higher training in psychiatry will have to become much closer to training in other specialties and there are two big drivers for this: the increasing role of the postgraduate deaneries in higher training and the establishment of the Postgraduate Medical Education and Training Board. The postgraduate deans do not understand the concept of having a large excess of trainers over trainees because this situation is unique to psychiatry. The argument for this system has been that trainees have the opportunity to choose the best trainer for their needs, it emphasises that SpR posts are supernumerary and ensures that trainers compete for trainees. This has worked reasonably well as long as the deanery

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funded SpR posts. However, recently in our region there was an increase in national training numbers (NTNs) available but not deanery funding for these posts. SpR numbers can be increased only if the trusts fund these posts themselves. It is unlikely that a trust would fund an extra NTN if the trust knew that SpRs would be appointed with that NTN to work in another trust. If there were the same numbers of trainees and trainers this might give the deaneries more control of SpR training in other ways. We could also move more quickly to 'professionalise' trainers by way of formal training and continuing accreditation.

Fifth, staff grade and associate specialist grade (SAS) doctors are currently employed to back-fill many posts where it is not possible to recruit trainees. Increasingly, SAS doctors are being encouraged to become consultants because of the severe consultant shortages in our specialty (Department of Health, 2003). Having different although equivalent ways to obtain a completion certificate of training (CCT) makes a lot of sense, however where does this leave the SpRs? Care must be taken not to demoralise SpRs. In the West Midlands, we are already beginning to see a phenomenon which severely disadvantages trainees following the conventional career path and moving directly from SHO to SpR training. Some SHOs are taking 'time out' (this can be a few weeks or a few months) to work as SAS doctors before applying for an SpR post. When they subsequently get onto the higher training scheme they have salary protection and some SpRs have the potential to earn double what their colleagues who have not taken any time out can earn.

Recruitment and retention in psychiatry continue to be problematic (O'Connor & Vize, 2003). The whole training system in psychiatry needs to be more flexible and responsive to needs. The West Midlands has the highest number of consultant vacancies in general adult psychiatry in the country (Royal College of Psychiatrists, 2002) and the largest numbers of SAS doctors. At present we have large numbers of doctors applying for SHO posts but only recently have we had sufficient numbers of applicants for the higher training scheme. Recently, the Department of Health altered the formula for SHO numbers in psychiatry. We applaud this change toward liberating the mechanisms for monitoring vacancies and adjusting numbers of doctors in training, but the system is still not flexible enough.

Finally, the needs of flexible trainees have to be recognised. An increasing proportion of doctors now want to train part-time, and psychiatry is one specialty with large numbers of part-time trainees. These trainees are a valuable resource, again there should be an acknowledgement of their differing training needs and thought given to how the increased proportion of part-time workers will affect workforce planning. Until recently flexible trainees were occupying one NTN, this resulted in a distorted picture of numbers of potential consultants willing to take on full-time work.

Conclusion

The Calman reforms have benefited SpRs greatly and acknowledge that these are primarily training posts. What is now required is a more focused yet flexible system of training that can cope quickly with changes in demand for trained psychiatrists. With pressures on psychiatric trainees from a variety of sources, i.e. deaneries, consultant vacancies and changes in training for other grades, the time has come to look again at how to optimise higher training. Greater emphasis will need to be given to the training, accreditation and continuing training of trainers. In contrast to the current informal methods, we suggest that to become a trainer all prospective candidates will be required to undergo basic preparation for education, e.g. principles of adult learning, the educational cycle, supervision and its uses, principles of assessment and appraisal. They would then need to demonstrate continuing learning as part of their personal development plan.

Psychiatrists are currently engaged in a vigorous debate about redefining the roles and responsibilities of the consultant because of high stress levels and burnout. It is no use elegantly redesigning consultant jobs without addressing the training that must render individuals fit for these roles.

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