Reflections on part-time training in psychiatry

A review after the first quarter century

Fran Reichenberg

We have seen many interesting accounts of people's training experiences on the part-time scheme published in this journal, and one or two interesting articles looking at broader related issues, for example looking at attitudes and awareness of part-time training among colleagues and the impact of these factors on recruitment to part-time training.

This article presents a brief account of the current position of part-time training in psychiatry. In recent months there have been some organisational changes to the scheme, and more substantial changes will occur with the unified training grade implementation. However, the basic ethos of the scheme remains unchanged from when it was initiated in Oxford by Dame Rosemary Rue with the Department of Health 25 years ago: to enable medical graduates to continue to work and train, and not be lost to the medical workforce because of competing domestic, health-related or other non-recreational demands on their time.

There are currently 603 part-time senior registrars and 424 career registrars nationally, of which 174 senior registrars (29%) and 80 career registrars (19%) are training in psychiatry. Compared with other specialities, psychiatry has one of the largest proportions of its trainee workforce training part-time. Part-timers represent 17% of all trainees in psychiatry compared with 8.5% for all other specialities.

To present this another way, Table 1 shows part-time senior registrars as a percentage of all full time senior registrars for all the specialities. Paediatrics and psychiatry show the highest ratios, and surgical specialities the lowest.

Geographical information is more sparse. Table 2 shows the distribution of part-time senior registrars and career registrars in psychiatry by region, expressed in terms of the regional population size. There would appear to be a trend towards part-time training being more prevalent in the South East, and less prevalent in the North West, with Wales having the lowest number of trainees relative to its population size.

Viewed from the perspective of gender, nationally only five of 603 senior registrars (0.8%) are male, of which two are training in psychiatry. Although part-time training was initially conceptualised in terms of 'married women' who were the group of doctors conspicuously leaving training, the scheme is equally applicable to men. Many people hold the view that the next most important development in part-time

Table 1. Some correlates of part-time training: between and within speciality comparisons

Speciality	Ratio P/T to F/T senior registrars (%)	Female consultants: % of all consultants	Female senior registrars: % of all senior registrars
Psychiatry	25	29	45
Paediatrics	31	31	50
Obstetrics and Gynaecology	23	16	35
Anaesthetics	17	22	27
Pathology	12	27	38
Medicine	12	13	28
Accident and Emergency	11	12	30
Radiology/Clinical Oncology/Nuclear Medicine	9	~23	~34
Surgery	4	4	7
All	15	18	31

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Table 2. Distribution of part-time trainees in UK regions

Region	P/T senior registrar	P/T career registrar	Population (thousand)	P/T trainees expressed as popn. per trainee (thousands)	Rank
North Yorks	16	9	6044	241.8	6
Trent	21	9	4673	155.8	3
Anglia/Oxford	25	10	5211	148.9	2
North Thames	27	14	6812	166.2	4
South Thames	36	13	6699	136.7	1
South West	16	7	6300	273.9	8
West Midlands	9	12	5215	248.2	7
North West	17	14	6603	213.0	5
Wales	6	1	2898	414.0	9
Total	183	89	50455	1855	

training will be the transition from a female dominated group of trainees to one in which men and women appear in equal numbers. However, flexible trainees must demonstrate that they have "well-founded reasons" for training part-time, and it may be that what constitutes a well-founded reason may be differentially interpreted for male and female doctors.

There are no data on the distribution of part-time training by ethnic background.

The general message to be drawn from these data is that psychiatry has and continues to lead the way, along with paediatrics, in terms of appropriate use of the part-time training schemes, numerically, and in terms of gender of trainees.

However, considerably more needs to be done to achieve equality and equity of access to part-time training across the dimensions of speciality, gender, geographical area, and possibly ethnic background.

How can the present pattern of distribution of part-time training be understood, and what does this imply needs to be done to achieve this ideal? Firstly, it is widely known that local attitudes to part-time training are pivotal in determining the availability of part-time training opportunities. The number of consultants in a region who have themselves trained part-time, the interests, training experiences, attitudes and views of the postgraduate Dean and speciality tutors, and peer group attitudes account for a significant part of the observed variations. There does appear to be a relationship between the proportion of consultants who are female and the proportion of the workforce who are part-time trainees (Table 1). It is relevant to note that the Department of Health have a goal of increasing the overall percentage of female consultants to 22% by 30th September 1998.

The academic culture in a locality does not seem to play a significant role in explaining these variations: possibly even the converse applies. For example, I myself have trained part-time in Oxford, a city known for its academic excellence and competitiveness throughout all the specialities. As a region it has a high ratio of part-time to full-time trainees throughout the specialities. Possibly centres of excellence may be less anxious or defensive and less prone to see part-time training as a threat to academic standards and reputation.

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Fran Reichenberg, *Training Fellow (Honorary Senior Registrar) in Child and Adolescent Psychiatry, Park Hospital for Children, Old Road, Headington, Oxford OX3 7LQ*

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