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Editorial

The needs of new consultants

Julian Beezhold

Abstract This editorial discusses the needs of new consultants with reference to existing research and attempts made to meet these needs both within the Royal College of Psychiatrists and elsewhere. Some future challenges for new consultant psychiatrists are identified and discussed. Initiatives that can help meet their needs on a personal and also on an organisational level are suggested. A call is made for new consultants to take control of their own destiny using tried and tested methods and thereby creating hope for their future.

This topic reminds me of my very first day in UK medicine as a locum senior house officer in geriatric medicine, fresh from the (former) colonies; and, keen to do the right thing, dressed to impress in a suit. I was very pleasantly surprised to find that everyone was very friendly, smiling and greeting me, but soon understood that only consultants wore suits. The next day I returned, this time appropriately attired and was equally surprised to have all the same friendly people from the day before ignore me completely. Orientation accomplished.

New consultants in psychiatry, who are within the first 5 years of their appointment, comprise about a third of the psychiatric workforce in the UK – a large and growing proportion. New consultants as a group tend to share a number of common needs and concerns, ranging from training deficits, problems coping with role change and workload, through to developing the skills required for surviving and thriving in the new National Health Service (NHS) and beyond. Research from specialties including psychiatry already gives us some idea of the nature and content of these issues (Houghton *et al*, 2002; Mooney, 2003; McKinstry *et al*, 2005). Work carried out in a variety of settings, including other medical Royal Colleges, gives us some direction in how to tackle these issues as a specialty.

The Royal College of Psychiatrists has already approved in principle the creation of a New Consultants Committee to address needs specific to this group (approved by Council in 2003). Now is the time to take a bold step forward by developing specific initiatives to meet their needs. This article will present a brief overview of the issues involved, along with some proposals for action.

How many new consultants are there?

In 2005, the NHS Workforce Review Team for Psychiatry estimated that the consultant workforce in psychiatry would number about 3805 in 2006 and predicted growth to about 4411 by 2010. According to their projections, up to 263 new consultant psychiatrists would be appointed in 2006, 403 in 2007 and a further 342 in 2008. Retirements were modelled to run at about 104 consultants per year throughout this period. Table 1 shows the team's predictions in 2007 (data collated from spreadsheets at www.healthcareworkforce.nhs.uk/workforce_review_team/wrt_proformas/medical.html; details available from author). Extrapolation from these figures suggests that approximately a third of all practising consultant psychiatrists will have taken up their initial consultant appointment within the preceding 5 years – and will therefore be 'new consultants'.

These projected figures are likely to prove to be inaccurate, as 2006 saw consultant numbers rise to 3805, some 240 fewer than predicted (The Information Centre, 2007). It is clear, however, that at any one time the number of new consultants who are within the first 5 years of appointment is significant.

New consultants are of course not a homogeneous group. Obvious sources of new consultants include UK-based 'graduates' with a certificate of

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Table 1 Consultant psychiatrist workforce predictions in 2007

Specialty	In post in 2005, n	Predicted annual retirements, n	Projected in post (from 2005 estimate), n 2008	2010
General	2086	56	2245	2420
Child	604	18	611	656
Old age	508	13	599	675
Forensic	239	6	283	313
Intellectual disability	206	4	220	232
Psycho-therapy	116	4	110	115
Total	3759	101	4068	4411

Source: NHS Workforce Review Team for Psychiatry (2007): see text for details.

completed specialist training (CCST) or a certificate of completed training (CCT) , individuals approved by the Postgraduate Medical Education Training Board under Article 14 (projected to be about 20 per year at present), and those from other areas such as European Union countries (estimated to currently account for about 48 consultants per year). Psychiatry in particular has seen a surge in recent years in numbers of International Fellows who have taken up consultant positions in the UK.

What do we know about the needs of new consultants across medical specialties?

There appears to be widespread consensus that specialist training in most, if not all, specialties fails to adequately prepare trainees for life as consultants. This ranges from failure to equip aspiring consultants with the skills to see through the glossy descriptions of posts, through to inadequate preparation for some of the key demands of the post itself.

Participants over several years in 'new consultant days' organised by the London Deanery described the transition from being a trainee to becoming a consultant as 'dramatic', being 'faced with a host of unanticipated responsibilities that required skills [they] didn't have', and said that the 'main challenge at this time was surviving' (Houghton *et al*, 2002). These new consultants identified several needs, including:

- the need for management skills such as business planning, negotiation, dealing with the problems of junior doctors and other colleagues, conducting interviews and taking responsibility for decisions
- the need for more information regarding the NHS and their immediate work setting
- the need for better prioritisation skills to deal with the workload and administrative pressures
- the need for preparation to cope with the role change, whereby they were now the person in charge, including how and where to obtain help
- the need for skills in managing difficult relationships
- learning how to say 'no'.

These findings have been replicated by research in many specialties, including accident and emergency/emergency medicine (Beckett *et al*, 2006), orthopaedics (McKinstry *et al*, 2005) and geriatric medicine (Sandler, 1992), and among hospital doctors (Mooney, 2003) and members of the Royal College of Physicians (Mooney, 2003).

An interesting and significant finding from the Royal College of Physicians' survey of new consultants was the striking difference between the 20–25% time commitment to managerial duties required in their consultant posts and the 5% of training time devoted to preparation for this (Mooney, 2003).

A research study commissioned by the Kent, Surrey & Sussex Postgraduate Deanery and the Kent & Medway Strategic Health Authority (Cray & Lawrance, 2006) specifically included 'recommendations for best practice in relation to setting up newly appointed consultants for success'. These included three main areas for action by employers:

- environmental factors
- engagement with new consultants
- support and enabling.

Environmental factors included:

- adequate office space
- information technology facilities
- adequate (one-to-one) secretarial and administrative support
- building a healthy working culture using a variety of feedback methods
- monitoring for bullying and blame cultures
- recognition of achievements in order to build ownership and pride
- mentoring and other networks.

Engaging new consultants should be achieved by:

- using feedback from existing consultants regarding barriers to engagement

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- planning for a new consultant's arrival, including formal welcome and induction
- using constant feedback to improve the process and identify what works well
- reviewing career planning procedures.

Supporting and enabling could be promoted by:

- ensuring that key staff are prepared for meeting the new arrival
- allocation of a 'buddy' to show and tell key information
- setting up a new consultants network
- providing key training
- including time in job plans for development
- early reviews with medical and/or clinical directors.

Do new consultants in psychiatry face special challenges?

There are a number of ways in which new consultant psychiatrists are discriminated against:

- lower pay for on-call hours
- significantly reduced pension rights compared with colleagues who began working in psychiatry before 1994
- suggestion of more 'clinical programmed activities' for new consultants than for established consultants
- threat of a junior consultant grade in the future
- exclusion from applying for Clinical Excellence Awards for the first year after appointment.

In my view they also face several special challenges. These include the nature, methods and consequences of service change in psychiatry, as flagged up, for instance, by the new consultants group of the Faculty of the Psychiatry of Old Age at the College (De, 2003).

Changing employment opportunities

The first of the challenges is the impact of a variety of changes and initiatives on the availability of job opportunities for newly qualified psychiatrists. The new financial climate in the NHS has disproportionately affected mental health services. This is reflected in cuts to budgets and services, including consultant psychiatrist posts. Government efforts between 2002 and 2006 to address the shortage of psychiatrists have seen recruitment of International Fellows and the introduction of the 'Article 14' route to specialist registration by experience. The expansion of the European Union in May 2004 saw increased movement to the UK by consultants from the accession states. The impact of these changes on filling vacant consultant posts is illustrated by the 28% increase in consultant numbers between 2002 and 2006, while specialist registrar numbers increased by only 6% (The Information Centre, 2007). The net result of this is that we now see more and more applicants competing for a decreasing number of posts.

Cost cutting

Second, mental health services are currently undergoing a phase of often extremely rushed and radical service changes forced through by the need to cut costs. This is naturally disturbing and often significantly demoralising as it brings with it even the potential threat of consultant redundancies. Often, unfairly, this is in order to subsidise deficits in non-mental health NHS services. These changes can of course be both good, with decreased waiting times and some increased job satisfaction, and bad, with some consultants feeling increasingly marginalised. The publication of *New Ways of Working* has been used as justification for some of these job cuts and changes despite the explicit statement that the New Ways of Working initiative 'is *not* about saving money, releasing resources for other things, nor about undermining the role of the consultant psychiatrist' (Royal College of Psychiatrists & National Institute for Mental Health in England, 2005: p. 5). Unsurprisingly, this has led to problems with the credibility of the whole programme.

The blame culture

The third major issue for psychiatrists is the profound and pervasive blame culture within which we work. We all dread suicides and homicides, not just because of the personal tragedy of the act, but also because of the certain knowledge that, where possible, we will be blamed by one or more of more than 15 different organisations/bodies that each have separate powers to individually investigate, criticise and sanction us in these matters.

The changing role of psychiatrists

The fourth challenge specific to psychiatrists is the issue of our professional and clinical role with regard to patients, and our relationships to other healthcare professionals both in mental health and the rest of primary and secondary care. Huge, seminal changes are taking place in the whole structure, funding, commissioning, delivery and functioning of mental health services, with more, such as payment by

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results (a form of fee-for-service payment: see Fairburn, 2007), due shortly.

Speaking out for psychiatry

The final specific topic relating to psychiatrists that must be confronted is that of our approach to acting as spokespersons for psychiatry. Attitudes of others towards psychiatry may often leave something to be desired. Yet, is it not we who must take a large measure of responsibility for this because of our long-standing collusion with and tolerance of unacceptable behaviour? For example, is it acceptable that it has required my personal intervention as a consultant to persuade a general hospital acute unit to accept emergency referrals of mentally ill people with problems such as diabetic ketoacidosis?

What has been done to meet new consultants' needs?

In 2000, the Royal College of Surgeons of Edinburgh commissioned the Adamson executive report on the training needs of new consultants. In response to the report's findings, it introduced a 2-day course specifically for new consultants. Key features of this course include attention to changing personal and NHS roles and responsibilities, and personal development. The increasing uptake of the course is felt to reflect the unmet needs of new consultant surgeons (Bonner, 2005).

Mentoring relationships, whether informal or structured, are commonly said to be very useful. The Department of Health and the Royal College of Psychiatrists have jointly recommended that 'new job descriptions [should] not be approved without a mentor being identified' (Department of Health & Royal College of Psychiatrists, 2004), in advice that could hardly be worded more strongly. The College recommends that the relationship between a new consultant and their mentor should ideally be informal, supportive and that the mentor should not have line-management responsibility for the new consultant (Dean, 2003).

Interestingly, new consultants who had joined units with 'flat structured cooperative environments where everybody is involved in decision making' reported some of the most satisfactory experiences of transition (Houghton *et al*, 2002). This is a critical point for organisations in the NHS as it has far wider implications than simply meeting new consultants' needs.

Over recent years a variety of initiatives have aimed at better meeting the needs of new consultants in psychiatry. Some are government sponsored, for example good practice guidance both for employers (e.g. Cray & Lawrance, 2006), and for new consultants themselves (e.g. Hardern, 1998). Some are cross-specialty, often deanery-led training initiatives, such as the London Deanery 'new consultant days'.

Improvements to the specialist training curriculum are constantly being made, with a major shift in the direction of competency-based training. The College is very aware of the concerns regarding the transition to consultant posts, and now, for example, puts significantly more emphasis on management training than in the past. New consultants who had been able to gain management training that included actual responsibility during their trainee years reported that this had been extremely helpful (Houghton *et al*, 2002).

New consultant groups and networks have spontaneously or deliberately been set up. These have started up both locally, for example in my own trust, and also nationally, for example with thriving new consultant groups active for several years now at the College, in the Old Age, Forensic and Liaison Psychiatry Faculties.

On a national level, the Royal College of Physicians of London has had a vibrant regionally elected new consultants committee since 1999. This committee has conducted research into new consultant issues, published guidance and hosts regular training events. In addition it ensures that, from the very beginning of their consultant career, consultant physicians have a voice at the very the centre of their College.

As mentioned above, the Council (now the Central Executive Committee) of the Royal College of Psychiatrists approved, in principle, the establishment of a College-wide new consultants committee. The purpose of this body would be to focus on coordinating and leading College work and efforts in an attempt to systematically address the needs of new consultants.

Further action

Complacency has already long since ceased to be an option. It is really important to give hope to new consultants – something that is within our own power to do. How? The very first step must be to cast aside the state of learned helplessness that is so pervasive among psychiatrists. We can and should find ways of actively rising above a position of passive acceptance.

Get involved!

Get involved personally, for yourself, by taking the first steps to control your own destiny as a new consultant within your own workplace or team. Consider all the options for your future and the impact of national political trends. If there are going to be changes, then perhaps it is better to be at the forefront exerting influence and shaping the future.

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Get involved locally or regionally in new consultant groups or initiatives for mutual support and to avoid re-inventing the wheel. Or start a group where there is none.

Get involved nationally, if you wish, in Faculty or even College-wide new consultant committees and initiatives.

The College has made it clear that the door is open – so let us step forward, together, and create a future that better meets the needs of new consultants in psychiatry.

Declaration of interest

None.

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