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Education and training

The future of psychiatric training after the Calman Report: a trainee's perspective

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Background

In September 1992 the Government convened a Working Party under the chairmanship of the Chief Medical Officer, Dr Kenneth Calman, because of concerns that specialist accreditation in Britain did not comply with European Community (EC) directives.

Two parallel forms of specialist registration have existed in Britain; doctors who gained accreditation from their medical college and were eligible to be labelled (T) in the medical register, and doctors who completed a shorter period of postgraduate training which met minimum European standards. Under EC rules no doctor who has European specialisation can be barred from being appointed a consultant and so the Government, Colleges and medical profession must agree on the integration of the two systems.

Dr Calman's working party, which consisted of representatives of the General Medical Council, Colleges, senior doctors and junior doctors, had the following remit: to consider postgraduate medical education and career progression in the UK in the light of European Community law, evaluate the scope for further harmonisation in Europe and advise the UK government of any immediate action that would need to be taken (Calman, 1993).

The response of junior doctors to the Working Party was far from unanimous. On one hand, the Collegiate Trainees Committee (CTC) of the Royal College of Psychiatrists favoured minimal changes to the present system. On the other, the initial submission of the Junior Doctors Committee (JDC) of the British Medical Association called for more radical changes which were opposed by many psychiatrists in training (Kehoe, 1992; Kisely & Morriss, 1992). In particular, some of the initial suggestions by members of the JDC leadership would have had the effect of weakening the consultant contract (Kisely & Morriss, 1992).

The final submission by the Junior Doctors Committee to the Working Party gained more widespread support and called for shorter, more structured training leading to a full consultant contract (JDC submission to the CMO's working party, 1992). Specifically the JDC's submission tackled the interrelated issues of manpower and education from the point of view of ensuring high quality and rewarding training; the medical profession's manpower difficulties could no longer be disguised by artificially raising the time in training before reaching consultant appointment.

Implications for psychiatry

After six months and nearly 60 submissions to the enquiry, the Working Party published its report in May 1993 which will herald fundamental changes in the way doctors work and train in this country (Calman, 1993). There is much in the contents that trainees of all specialties can welcome. The Working Party recommends the introduction of improved training programmes by the end of 1995 and suggests that the Royal Colleges specify clearly their curricular requirements no later than July of next year. Training should be structured, and allow flexibility, choice and competition based on merit. Such improvements would allow the duration of training to be reduced to seven years or less.

The report considers that specialist training should be defined as the period between full registration and the gaining of a certificate of specialist accreditation, termed the Certificate of Completion of Specialist Training (the CCST). The CCST would be the sole form of specialist accreditation and be based on EC law although reflecting the situation in Britain. The existing "T" designation in the medical register would be replaced by a new label ("CT") which would be awarded to any holder of the CCST or equivalent EC qualification. The recommended time for training in any specialty would include relevant experience as a senior house officer (SHO).

The Working Party also tackled related manpower issues; the consultant contract should remain the same and entry into the grade would be dependent

on possession of a primary medical degree and the recommendation of an Appointments Advisory Committee (AAC) as is currently the situation. The report recommends that the current expansion of consultant numbers should be increased in order to accommodate the envisaged changes in medical training.

Other proposals may be more contentious such as suggestions for a unified training grade and the abolition of the distinction between registrars and senior registrars. In Australia there is no such distinction among trainees, and some specialties in Britain such as urology are moving in the same direction. On the other hand, an amalgamation of the two grades may have implications in terms of leave and job description. For example, where a single training grade already exists, there is usually only one tier of juniors on call.

In psychiatry the working party noted that training lasts for seven to eight years, comprising three to four years basic specialist/general professional training, and four years higher specialist training. By contrast the minimum requirement for European specialist status is four years although direct comparisons in terms of duration were felt to be misleading. There is no formal accreditation as such; completion of training is achieved through appointment as a consultant or the completion of four years as a senior registrar. The report comments that accreditation procedures in psychiatry will need to be reformed in view of EC law and that the target duration for training in psychiatry should be five to six years.

Some unanswered questions remain. The report is primarily concerned with registrars and senior registrars; recommendations for the future of the SHO grade are more vague. At present SHOs are a heterogeneous group; some are doctors sampling particular specialties, some are gaining experience before entering general practice, and some are doctors who have made a definite choice of career but are unable to gain entry onto a registrar training scheme. In addition there are marked differences between specialties in the purpose of the SHO grade, and the roles these doctors perform. In psychiatry there has been some blurring of the distinction between SHO and registrar; it is usual to work as a psychiatric SHO before joining a registrar rotation, and the two grades perform similar tasks including sharing the same on-call rota. In other specialties the content of the SHO year can be quite different; in general medicine or surgery trainees are encouraged to work in different specialties in order to widen their experience, and the registrar can be quite separate from more junior colleagues. A solution that is appropriate for surgery may therefore be quite inappropriate for psychiatry.

The Certificate of Completion of Specialist Training will not only replace the (T) register but also existing European certificates of specialist training granted by the General Medical Council, the Certificate of Specialist Training (CST). These are still available from the GMC under current less stringent EC regulations than those envisaged for the new certificate and which remain in force until replaced by the new legislation required for the CCST. The report fails to consider solutions for this group of individuals and states that some transitional arrangements will need to be considered. Although some may be eligible for the new certificate, others may not meet the stricter requirements. Automatic transfer for all existing holders of the CST to the new CCST would appear to be the least unsatisfactory solution. Of the possible alternatives, retrospective removal from EC specialist status would be contrary to natural justice, while continuation of the two in parallel would defeat the whole object of the exercise: one single certificate of specialist training recognised under EC law.

A further question is the status of doctors who have acquired the CCST but have not been appointed as a consultant; the "time-expired post-CCST trainee". Unfortunately the Working Party did not accept the idea of a holding period of up to one year during which a trainee could keep his or her training number while looking for a suitable post. The report discusses the possibility of proleptic consultant appointments; the successful candidate assuming the post upon the award of a CCST, but largely leaves the question open and recommends that these manpower issues be considered more fully through such mechanisms as *Achieving a Balance*.

The last area of doubt concerns the future of the consultant contract; although Dr Calman and his colleagues state that the end of training should remain the existing consultant contract, they also comment that some of the work carried out by juniors will be subsumed within the consultant workload, and that there is likely to be greater diversity within the grade. The profession as a whole needs to be careful that this does not mean the introduction of a subconsultant specialist grade under a different name (Kisely & Morriss, 1992).

Our response

In many ways specialist training in psychiatry has already made the changes envisaged in the report. Psychiatric trainees enjoy important advantages over those in many other specialties; training is more structured and consequently shorter in duration, and day release for attendance at courses is the norm rather than exception. On the other hand, the Royal College of Psychiatrists, and especially the Collegiate Trainees Committee, should carefully consider some

of the additional proposals so as to improve postgraduate education training still further. Training in Australia and New Zealand where there has been a unified training grade for many years, and where the fellowship examination is at the very least equal to UK membership, only lasts five years; reducing the duration of training in this country to a comparable level should therefore be a realistic aim.

The report will be the subject of a consultation process over the remaining part of this year. Psychiatric trainees need to ensure that their views in the future of training are heard through both the Collegiate Trainees Committee of the Royal College of Psychiatrists and the JDC. Both organisations have important and complementary roles in medical education and it is to be hoped that the two organisations can work closely together to ensure the best deal for psychiatric trainees.

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Expectations of prospective senior registrars and those who appoint them

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Access to a senior registrar post is growing more difficult because of increasing competition. The College Court of Electors and Joint Committee for High Psychiatric Training have agreed only two criteria for appointment as SR in Psychiatry (possession of MRCPsych and at least three years of general professional training), but, despite heavy workloads, busy timetables, and the need to prepare for the membership examination, clinical skills and dedication to patients will not ensure career progress if they are not accompanied by other aspects of training, sometimes with insufficient facilities and supervision. Indeed, Lewis (1991), after reviewing a group of applications for SR posts, found that the only variable which predicted likelihood of being shortlisted was having published: "Trainers generally believe that evidence of completed research and publications say more about a trainee than a good reference ever can".

Crisp (1990) suggested that all registrars complete a small project as a requirement of completion of training.

What do registrars believe they should offer SR appointment committees? How does this correlate with the views of those who appoint senior registrars? We asked both groups.

The study

This study was designed to reach all career registrars currently working in all 31 hospitals and psychiatric units throughout the North West Thames Regional Health Authority and those professors, senior lecturers and consultants who are, through their university and College positions, often involved in the appointment of senior registrars in the same region. They were asked which factors they would consider essential to obtain a SR post. The questionnaire consisted of ten factors, which had to be answered by ticking one of three categories for each factor: Essential, Useful but Not Essential, and Not Relevant.

These factors were:

(1) having research in progress
(2) completed research
(3) publications
(4) working in a teaching-hospital rotation
(5) experience of three years in adult general psychiatry
(6) managerial skills
(7) ability to work in a multidisciplinary team
(8) wide range of outside interests