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Training late – from branch to mainline at 40

In 1996, after working in career-grade posts in psychiatry for over 5 years, the authors began training at Senior House Officer (SHO) level with the intent to sit the MRCPsych and enter higher specialist training. We feel that our experiences of coming late to training may be of interest to other doctors, and in particular we describe our experiences of the transition from non-training to training grades. Currently, career-grade doctors who toil on the unglamorous branchlines of psychiatry face difficulties in transferring to the mainlines because relevant experience gained in these grades is not recognised for MRCPsych. This may act as a deterrent to doctors who might, otherwise, train successfully to consultant level. We propose the use of career portfolios to facilitate movement between training and non-training grades.

Who we are

C.L. is a 44-year-old mother of two with SHO experience in A&E departments and 5 years in the Doctors' Retainer Scheme while the family was small. S.L. is 45 years old with three children and vocational training in general practice. We were both clinical assistants in psychiatry for several years prior to training. One of us took a Diploma in Adult General Psychiatry.

Why did we decide to train?

We entered clinical assistant posts at times when our family commitments were considerable and, for us, incompatible with the rigours of training. Later, the balance changed and we felt that our careers were drifting. There was uncertainty about the future and concern that with no relevant qualifications we might not secure interesting jobs in the long term. Our medical peers were fully trained and settled in career posts. Non-medical friends were returning to work and advancing their careers. At this point there was outreach by the Regional Associate Postgraduate Dean, who spoke about opportunities for flexible training. Locally, the clinical tutor was encouraging and part-time training became a practical possibility.

Finding an SHO post

For anyone who wants to return to training it is necessary to find out about the local scheme and take advice from colleagues and the clinical tutor. For those wanting to work flexibly, it is also necessary to contact the regional advisor for flexible training and the post-graduate Dean's office. After formal interviews we were employed as supernumerary SHOs. The medical director negotiated with the Region over funding, because we were both flexible trainees. The clinical tutor showed his support by arranging our first two jobs as SHOs as part of his team. Later, one of us was able to work full-time for a period.

Making the transition

We both had experience as SHOs in other specialities but had no experience of being junior trainees in psychiatry. We came to our SHO posts with valuable experience in A&E or general practice medicine and expertise in behavioural or psychodynamic psychotherapy. We were familiar also with multi-disciplinary working and with assessing and managing a range of patients under consultant supervision in community psychiatric settings. We had little experience of in-patient psychiatry. Feeling de-skilled can be an unsettling experience but this was managed tactfully by our training supervisor. He also encouraged us into MRCPsych examination preparations, which we both doubted we could pass.

Our younger colleagues were generally tolerant of us, although sometimes we did eye each other with mutual surprise. We had to remember to be tactful about any perceived demands that our flexible training might put on our colleagues, for instance in organising on-call rotas. We did, however, have a historical perspective on developments within the local service, which sometimes was useful to juniors tackling change. We both took our turn as junior doctor representatives and made every effort to represent the body of junior doctors rather than ourselves.

Certain things eased our paths through SHO training. The opportunity to work flexibly was essential for our return to training and the flexible training scheme also offered peer support, as did our friendship. We are grateful to the clinical tutor, who was even-handed and supportive throughout our training. The consultant body was tolerant and helpful towards us and it appeared that at SHO level age is benefit-neutral to the employer. With patients, it is rarely a disadvantage to look older,

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although it may feel like a disadvantage to be older and exhausted in the middle of a long night.

We also found, once we had embarked on training, that although there were no trainees with quite the same career paths, psychiatry is a broad church and there are a great many trainees from the UK and abroad who do not fit the picture of the 'typical' SHO, but who may be older, have experience in psychiatry or other specialities or indeed may be making a complete career change.

Studying late

Studying late did not, for us, mean studying late into the night. We found that we needed to be organised and to adopt learning techniques that allowed us to be flexible – we became adept at doing multiple-choice questions while waiting for the children.

Preparation for the clinical examinations, as for everyone, involved practise with colleagues and mock exams. We also needed to re-learn the game of examination taking by adapting our clinical skills and learning to speak the right language. It was stimulating to acquire the foundation of knowledge in basic sciences, psychopathology and clinical sciences that previously we had only a nodding acquaintance with or that was entirely new to us.

We have both passed both parts of the MRCPsych at the first attempt and are now in higher specialist training. Effectively, we each have 20 years of future service with the NHS ahead of us. Although we have trained part-time, we would not necessarily wish to work part-time in substantive posts.

What insights have we gained

We feel that it has been worthwhile to transfer late to training and we would support other colleagues taking a similar path. We would support the concept of flexible training as extending to include the opportunity to work part-time and also longitudinal career planning for men and women, with flexibility of movement between career and training grades. Haley (1973) describes a family life cycle in which demands on carers vary at different life stages. We would suggest that future training in psychiatry should include recognition of this.

For us, starting late has demanded a great deal of patience. We recognise that the College must have a standardised approach to achieving examination eligibility. However, we felt that it was unfair that none of our several years of well-supervised experience in psychiatry as clinical assistants was recognised for examination purposes, even though brief SHO experience in other specialities was.

Non-career-grade doctors can feel that they are taken for granted. They are often expected to take responsibility above their training level but in line with their clinical experience. Their true contribution to patient care may be unrecognised. This is mirrored by the College's lack of recognition of non-training-grade experience, even in well-supervised posts, for people crossing over into training. In the future all doctors will have to participate in continuing professional education in line with the move towards improved standards of patient care and professional self-regulation as described by the Department of Health (1998). Revalidation is also upon us. This will include non-training-grade doctors and will make it necessary to improve their opportunities for further education.

Career portfolios for all

Holloway has described the concept of a career portfolio as a tool for documenting continuing professional development (CPD) in line with the requirements for revalidation and professional self-regulation (Holloway, 2000).

We would propose that the College considers adopting a 'career portfolio approach' for all training and non-training doctors. This would facilitate career planning and the transition between posts, and would allow individuals to demonstrate proficiency that may be taken into consideration for examination eligibility. This may encourage some people to move into training and qualify as much-needed consultant psychiatrists. We would suggest that well-documented and validated experience in non-training-grade posts in psychiatry could contribute towards eligibility for MRCPsych, just as much as 6 months of experience in another speciality such as A&E or obstetrics. Trainees could develop career portfolios that allow them to demonstrate good training experience throughout their careers in all types of posts.

We hope that our account of our experiences and proposal of career portfolios to enable greater job flexibility will provoke some debate. We also hope that our description of how we coped as late-entry SHOs might encourage others to step back onto the training ladder.

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