The future of post-graduate training in psychiatry in Ireland

Anthony Clare

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The following is an address from Prof Anthony Clare to an Irish Psychiatric Training Committee's Think-in Day on May 5, 2005 at Stewart's Hospital, Palmerstown, Co Dublin.

Thank you for inviting me here today....

It is worth our while to remind ourselves of why we are where we are at present. Our situation could not be more bewildering. There is or are:

- A new Mental Practitioners Act
- Changes recommended, mooted and underway in the Medical Council composition and its responsibilities
- The imminent demise of the Postgraduate Medical and Dental Board, a Board we took for granted while it was alive but now we wring our hands not with anticipation but with sorrow and wonder what is going to happen next
- The establishment of the Health Services Executive.

It's very tempting to be paranoid about the Health Service Executive. It seems to be responsible for everything and to have no end of ambition and appetite. However, if you have met, as I have, one or two of the members (of that executive) they seem in a state of shock as they stagger from one health service crisis to another. They are also working with a Minister who wants rapid solutions to problems. Consumers are also seeking a greater role in the how they are treated and how service is organised. Consumer influence is impacting everywhere, for example in the expanded Medical Council. They will play a greater role in prized things such as post-graduate education and training, professional responsibility, and professional scrutability.

Trainees are demanding greater training and more flexibility in how it's delivered. They often don't mean greater flexibility about professional expertise, although they do mean that too sometimes, they mean flexibility in time. They recognise a new relationship between the private and the public, between their personal lives and their professional lives.

We, as a profession, have preached for years about a more balanced approach to life – but never actually practised it and certainly have never taken it seriously. Those we've preached it to have taken it seriously. Our new trainees have looked at the kind of lives that they must lead and said "I don't want that." And they are now in the position to say what they do want. We are not able any longer to treat trainees quite as cavalierly as we did 15 or 20 years ago. We compete for trainees in a market that's highly competitive; we need the best. We seek the best but the best is expensive, as industry will always tell you.

There are changes too in our views of training. We once had the notion of a system that was a once off "thank God it's over – now I can do what I like," which is the system I lived in to a very large extent. Now my colleagues and I are imposing a much more lifetime accountability and competency model - on you and your trainees.

We seek an assurance of skills, expertise and knowledge that evolves, grows and changes in line with society's development and the changes in our specialist knowledge base and indeed the changes in our expected role.

We also face a change in the relationship between psychiatry and other specialities: psychology, social work, occupational therapy, general medicine itself. I could go on and on - about the proliferating area of counselling and alternatives therapies.

Europe's influence is increasing and this has changed many things. It has certainly affected our relationship with the Royal College of Psychiatrists. Once I would have argued strongly against changing that relationship in any way. Now it doesn't seem to matter anything like as much. And be careful about listening to dinosaurs such as me; the world in changing very rapidly.

I wouldn't recommend any precipative moves such as a startling declaration of independence - but evolutionary change is happening anyway.

I picked up a useful piece of information here today. I never realised, for example, that there are 600 members of the Royal College of Psychiatry in Ireland. I never thought that that amount of money is crossing the Irish Sea. I didn't appreciate how important Irish accreditation is to the Royal College of Psychiatry. The College is fighting for its existence. I have no doubt that, in the future, they may be very interested, in return for a large fee, in accrediting our programme – an entirely different relationship but yet a very similar one.

Irish psychiatry's demography is changing too. I'm struck by how much more female - and how younger our profession is. The number of new consultant psychiatrists appointed in the past ten years has increased.

This is a more energetic speciality; you won't stay that way for long. And so this is the moment. The challenges have arrived just as the energy has. I was relieved to hear people today prepared to ask the heretofore unthinkable questions about critical issues. For example:

- Do we have exams?
- Why have exams?
- What sort of exams?
- Where should they be?
- How should we examine? Who should we examine?
- How should we preserve our external accreditation?
- What should our relationship with Britain be?
- What about Europe?
- What do we want our psychiatrists to look like?
- How should we represent ourselves?
- Where should we be when the cash is handed out?

These are all absolutely crucial questions and you as a

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group cannot control the answers but you need to be where those questions are being debated and where people are struggling to solve them.

So turning to the three groups, you've already heard from the three rapporteurs. Let me just address two or three points.

Take this issue of independence. Well, I know this, having sat on a number of bodies, most recently this medical education and training offshoot of Hanley, that argue about who is going to be responsible for postgraduate education let alone psychiatry – postgraduate education. How is this training going to be funded? Does the Department of Health really know how costly it is? Do they know how it is currently funded?

The Department haven't an idea how postgraduate training is currently funded. I was at a meeting recently, I don't think that this is breaching any confidentiality, with a Department of Health representative who could not believe the figures that Professor Muiris Fitzgerald produced for the cost of educating a medical student in Dublin. That is the scale of some of the pretended and genuine ignorance. So when you think about the HSE in its current manifestation; it is nervous about what it's facing.

We, being psychiatrists, know that the first thing that we have to do is to understand their anxiety. Their anxiety is that whatever we come up with will be extraordinarily expensive. And I must say they'll be right.

It was very interesting listening to Arthur Tanner's elegant illustration of how far the Royal College of Surgeons has developed. They have maintained their association with the British Royal College but nonetheless taken control of their own education and training and I suspect given the British some new ideas too. They achieved this using funds that they have clearly obtained from their College's education of foreign medical students - at a fairly substantial price.

They also winkled funds from the Department of Health. They did this because the RCSI is a powerful, united, clear-speaking, forceful belligerent often insensitive body and just says: this is what we want.

And so the first message I got from today is the message I've also got sitting on the MET – that whatever happens to the PMDTB, we need a very clear body that says this to the HSE: you can't do it - we'll do it for you. It's possible that the HSE won't let us but I don't know about that. I believe that the HSE is beginning to realise the sheer scale of what it's been asked to do.

The beginnings are there. They have to negotiate with someone. They have to talk to someone with expertise in postgraduate education and training. The IPTC and the Irish College and the links with Britain all constitute a very rich resource. But we need to speak clearly and with one voice. We need to be representative and be ahead of the game. So, like the Medical Council will have, we must have close ties with the consumer and the parallel professions that work with us in the multidisciplinary teams.

You'll note I left out Mental Health Commission and the Mental Health Act changes. There the emphasis is on MDT with other specialist groups. There the battle is who runs what and does it need to be psychiatrists in control. Well I don't know how that battle is going to pan out but I do know that you, you, it's going to be you, I'm two years from retirement, influencing, working any new system. Some of the people that sit on committees, talk grandly and write papers in prestigious journals, are often gone by the time that the changes that they wisely or unwisely supported are implemented.

When I look around this room most of the people I see are going to be part and parcel of the new health service and certainly the psychiatric service. I was glad to hear from Kate and Mary that, slowly, a coherent picture of what it will look like is beginning to emerge. There were some hints in the contributions on the United States and Europe of what such a body might look while. This country is prized for its political and manipulative skills and it strikes me as not impossible, given the turbulence across the water, that we can negotiate an arrangement that suits us and gives us greater control over any examination that we run while at the same time respecting what we get from the UK.

The Royal College of Psychiatrists wants us too. We pay. A lot of money goes to London and in return we get other things. But don't ever think for a minute that they don't want us or that we've been clinging on there. They do and they will and it seems to me that the whole issue of the role that we play vis-à-vis each other is going to change over the next decade.

What is meant by this notion of an independent Irish body: a body that owns. Over the years I've felt less and less ownership of the current examination, that the trainees I'm teaching are going to an exam that seems more and more distant from me and to judge from talking to them more and more distant from them too. It's a necessary evil that frees them into a new world. I really think we can do better than that and I think that the Royal College of Psychiatrists feel that they can do better too.

Another question we must address is what kind of psychiatry we want to develop here in Ireland? The contribution on Europe showed an extraordinary spread that is not quite what you imagine it to be. For example, I imagined the Dutch or the Scandinavians to be much further ahead and Southern Europe to be further behind. I didn't find any consistency at all. It doesn't have a north south divide. Some of the programmes in other countries that I had expected to be broader and more developed didn't seem to me to be so.

So it does seem that we operate from a potential basis of strength. We are, to an extent, further along and this allows us to look at the kind of psychiatrists we want and the skills we want them to have. That's what the Medical Council is going to be asking the specialities – to define their core competencies to say how you'll train and to say how you'll audit and evaluate them. To date we've said that we do this through the British College Membership. I don't think that that is going to work very much longer.

The first group tackled the issue of structure and suggested some kind of national body that would have an overall responsibility for issues such as education, training, recommendations concerning funding and budgeting. You know that there was a strong fight for the setting up of a central training authority responsible for all postgraduate medical education with a budget from the Department of Health and run by the professional bodies. The Department of Finance, I suspect, wouldn't buy that. Well the bones of a possible alternative are still there. The existing thirteen

specialist bodies that are responsible for training form, in an ad hoc way, a body that speaks for postgraduate medical training in general.

We mustn't underestimate the funds that are involved. I don't know if anyone has audited the amount of money that people pay on membership and fellowship fees, the funds that are paid out in examination fees, the amounts of money that are paid for accreditation.

At the moment accreditation is happening in a variety of areas. Hospitals are being accredited by external bodies, are in turn accrediting across regions, across domains. Again it is necessary for any thinking in this area to allow for a variety of possible models.

The other thing to bear in mind is that, at some stage, all junior posts will be training posts. What will happen the other posts with ambiguous training status currently occupied by junior doctors? We cannot go on as we are at present. Our mission statement should be that the postgraduate education and training environment will be attractive to all medical graduates and deliver a high quality schemes that will result in sufficient number of fully trained competent doctors to deliver a patient centred health service for this country.

You may think that this is an awful lot of goo. However, if you're sick you don't. You want a high quality, patient centred service delivered by properly trained, accountable, audited and continuously educated medical personnel.

That's what this is about. There's no point in throwing bricks at each other, being paranoid over the HSE , fighting actions to preserve responsibility for this or that. The pressure is on to deliver this kind of service. We receive fair amounts of money and most of us feel that we do a remarkable job with very scarce resources. No one will thank us, though, if we miss this opportunity to put together cohesive arguments for the necessary means to deliver the excellent service that we want to provide.

The other two discussion groups had a more difficult task – in a sense. The shape and process of accreditation depends upon the overall body, the representative quality of it and the degree to which there is true debate between those organising and planning education and training and those delivering it. This means virtually every consultant. So when you start talking about the shape, the length of training, ring-fenced teaching sessions – it will all have to be fought for.

If you want ring-fenced training sessions then you want contract change to take account of teaching and training. You are going to have to organise this. No one else has the kind of expertise that you have. No one in medicine has it, certainly not in the Department of Health, or on the Medical and Dental Postgraduate Training Board save through your representatives. So it is very much in your hands.

The same applies to the process of accreditation. This could be decided by our political masters. Change could happen here by default. I don't get the feeling that the HSE is in any position to take over accreditation along the lines that that some of you fear - but the vacuum is there. We have expertise, the drive and energy to bring about the changes necessary. The question is: have we got the structure to put all of that together and to make sure that at every level, where the issue is discussed or reported on, psychiatry is there speaking clearly and knowing what it wants?

I wish you well because I think that this isn't going to be decided over two years. It may take five years or more. It sounds (like) that those currently occupying representative positions in psychiatry are well aware of the scale and dimension of the challenge and seem to be very genuinely oriented to ensuring that when Irish psychiatry speaks it speaks clearly. I think that a lot of very interesting ideas have come out of it and I hope that they will be pursued further. Today's discussion should lead to important recommendations and decisions. I know that a college meeting in June will develop these points further and, I hope, bring them to a conclusion.