Psychiatric Bulletin (2009), **33**, 309–312. doi: 10.1192/pb.bp.108.019737

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Rationalising medical careers

SUMMARY

This article assesses the quality of higher psychiatric training opportunities under Modernising Medical Careers (MMC) and compares them with the existing specialist registrar (SpR) grade; the UK psychiatric educational literature is reviewed, and trainee concerns reported. Anecdotal reports of higher training losses under MMC suggest disparity between specialty training year 4 (ST4) and the first SpR year. The roles, controversies and losses of protected clinical special interest sessions and the research day are reviewed. UK psychiatric literature notes under-utilisation and poor supervision of these highly valued protected training sessions, with suggestions for improvement. The sacrifice of protected training to service provision may have implications for training quality, leading to under-trained consultants in the long term, to the detriment of patients.

Now that the cortisol levels around 'MTAS 2007' (the Medical Training Application System) are normalising, it is time to reflect upon the first few months of a new training system. Problems with the implementation of Modernising Medical Careers (MMC) have been well described.[1] Among the findings of the provisional Tooke Inquiry report was confirmation that MMC was, at least partially, designed to solve the bottleneck in all medical specialities between senior house officer and specialist registrar (SpR) by creating a combined run-through grade. Higher training was reformed over a decade ago after Sir Kenneth Calman's report[2] and MMC was not designed to repeat this process.

However, higher training reform has now occurred in the specialties offering higher training MMC posts. In psychiatry, there are concerns that the new higher training pathway, like much of MMC, has at best been poorly prepared and at worst is without need or evidence base. This article seeks to compare the theoretical higher psychiatric training opportunities under MMC to the existing SpR grade. We reviewed the UK psychiatric educational literature and publically available College documents. We also collated numerous anecdotal expressions of concern from trainees in new higher training posts, as reported to the authors in their capacity as local representatives.

Despite numerous assurances that specialty training year 4 (ST4) would be equivalent to the first SpR year, early experiences suggest otherwise. In some areas there appear to have been numerous losses to higher training under MMC: loss of half the clinical special interest sessions or the research day; dual training opportunity; and supernumerary status.

The old system

Psychiatric higher training is different from other specialties in that specialist registrars have been supernumerary, and have been allocated 20% of the worked week for clinical special interest sessions and 20% for a research day.[3] 'Dual training' allowed for a fourth SpR year in another specialty leading to dual accreditation at completion of specialist training. The Royal College of Psychiatrists has acknowledged a service need for such consultants.[4] Supernumerary status allowed for flexibility in job planning around training rather than service needs. Existing specialist registrars have accessed these training opportunities, the quality and quantity of which has historically been rigorously defended by the College.

The *Higher Specialist Training Handbook* recommended that special interest sessions be used for special clinical interests, to equip trainees with suitable speciality experience by the time of completion of training, particularly in areas where trainees and supervisors agreed on a training need not covered in their primary team.[3] Research sessions were intended to encourage the application of critical appraisal, and to further academia and science in an under-researched specialty. Both concepts have sustained mixed views.

Critics of the research day have cited poor supervision, unclear outcomes and a perceived disconnect between higher training and service needs.[5] Vassilas & Brown found that only a third of programme directors and trainees believed that the research day was being 'utilised effectively'.[6] Criticism has arisen as a result of the low publication rate (64%);[7] although this is a controversial gauge of training quality, further discussion of which is outside the remit of this article. In contrast, a survey by Okolo & Ogundipe found that most consultants favoured the continuation of the research day, undisplaced by clinical work and linked to clear outcomes.[8]

More recently, a survey on the special interest sessions reported that 90% of specialist registrars received protected special interest sessions and desired no changes.[9] Both trainees and trainers valued special interest sessions as 'useful and integral parts of higher training'. Respondents believed that two special interest sessions were optimal, and suggested improved guidance on the provision of supervision and monitoring.

Trainees and consultants alike have valued both the research day[8,10,11] and special interest sessions[12–18] for their benefits to training experience across a very broad spectrum of areas (Box 1). Despite noted concerns , both the literature and more recent trainee views consistently call for preservation of these training sessions, improved

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Box 1. Literature-reported applications of special interest sessions as used by higher trainees

- Specialist clinics
- Higher degrees
- Teaching
- Private study
- British Medical Association (BMA) activities
- Service development
- Management skills
- Clinical audit
- Non-statutory sector experience
- Public health

supervision and clearer outcomes, as suggested by Vassilas & Brown.[6]

A brave new world

The ST4 entry requirements, interview process and salary scales were strikingly similar to the existing SpR recruitment process. With no forewarning and amidst the implementation difficulties of MMC, the situation changed in some deaneries at the onset of the first ST4 posts in August 2007. Distressed ST4 trainees in London reported (anecdotally, by personal communication to the authors as local representatives) consistent concerns regarding the changes to, and disparity in, training opportunities (Box 2).

It is unclear what has happened to dual training under MMC, but no such schemes were offered by deaneries. It is not clear, for example, how forensic child psychiatrists will be trained in 3 years under MMC. Supernumerary status similarly disappeared. Many ST4 trainees have expressed disillusionment with apparently poorly planned jobs and inadequate communication by responsible powers. They fear that the higher training experience has been damaged – and that changes were inconsistently applied across London and the UK.

The process

Examination of College minutes revealed that a query regarding the status of special interest sessions/the research day was sent to the Postgraduate Medical Education and Training Board (PMETB) in January 2007. The PMETB has superseded the Medical Royal Colleges in holding overarching legal authority on training post approval and quality. The College's Psychiatric Trainees' Committee opposed a reduction in special interest sessions/research day sessions for ST4 trainees and specialist registrars prior to 2010 '. . . as this had never been agreed at ETSC [Education and Training Standards Committee]'. The Psychiatric Trainees' Committee recommended that 'the next few years should be used to audit and agree the competencies and outcomes . . .'.[19]

Once the scale of the inequities became apparent from trainee reports, the Psychiatric Trainees' Committee wrote to the Dean (now President) in August 2007 with

Box 2. Anecdotal concerns expressed by ST4 trainees

- Prior to the College guidance, certain North London trusts condensed the special interest sessions and research day into 1 day, and replaced this 20% of protected training with standard clinical service sessions
- In contrast, other parts of London, Scotland, and many other deaneries retained both protected training days, and are largely treating ST4 trainees and specialist registrars equally
- Three ST4 trainees have reported ward-based job plans and resident on-calls at core-training level
- Two ST4 trainees with pre-existing research and higher degree commitments have reported insufficient job plan opportunity to fulfil these. At least one trainee had to abandon their role in a clinical trial due to a static job plan
- Within the same trusts, specialist registrars and ST4 trainees receive approximately the same pay scales for different amounts of clinical work within the trust
- None of these fundamental alterations were communicated to ST4 trainees as applicants or at induction, and significant confusion about special interest sessions/research day protection existed at the start date

concerns that, 'whilst this issue is still being debated within the specialty, many trusts have gone ahead and reduced the time available for these essential training opportunities from two days to one'. These quality assurance issues were again forwarded to the PMETB by the College.[20] The Psychiatric Trainees' Committee is currently quantifying training-post quality by surveying trainees in four English deaneries.

Several weeks after new training posts commenced, the Education and Training Standards Committee subsequently announced the reduction of protected higher training sessions into '1 day of research and study', with a caveat that special interest sessions may be arranged 'on an individual basis in discussions with the Training Programme Director, the Director of Medical Education and the respective Deanery'.[21]

For many, little indication or guidance was available from deaneries before start dates in August 2007, leaving individual trusts or educational supervisors to decide on significant training issues. Confusion seemed to predominate, and neither the generic MMC website guidance nor the MMC *Gold Guide* (which clearly focuses on core training despite replacing the Higher Training Guide) comment on these fundamental modifications.[22]

Implications for future training

The ST4 trainees now appear to be receiving inequitable training when compared with other higher trainees. Loss of these opportunities will likely impair access to gaining specific competencies, which are the cornerstone of MMC. Disadvantaged ST4 trainees will be competing with other ST4 trainees and dual training or recently starting specialist registrars when all these parallel cohorts complete training around August 2010, in an increasingly competitive consultant job market.

The new system disappoints the reasonable expectations of many psychiatric juniors who have been

https://doi.org/10.1192/pb.bp.108.019737 Published online by Cambridge University Press

working towards higher training for years, and who may have had higher degrees or research in place prior to August 2007. The inconsistencies that have ensued threaten to split higher trainees, when professional unity is called for. That these reductions were already in place in some areas on the first day of MMC suggests that the decision had been made prior to August. Why there should be an agreed diminution of training when deaneries have historically funded training is not clear. How SpR-level posts of debatable training quality were approved by the PMETB brings the quality assurance process into question.

That the Education and Training Standards Committee should support these cutbacks against the literature and trainees views is unfortunate. A less charitable observation might be that current National Health Service financial pressures played a role in squeezing more service out of higher trainees who, by virtue of being the first ST4 cohort, have not been offered a chance to utilise the protected training opportunities afforded their immediate predecessors. These ST4 trainees have played no role in moulding consultants' perceptions of the utility of existing special interest sessions/research day. Concerns have been expressed that current SpR training allowed too much flexibility and lacked boundaries and that special interest sessions/research days were inappropriately utilised. Yet with careful supervision, agreed goals and suitably validated assessment tools for defined training outcomes, these concerns can be remedied without the need for reinventing higher training.

It could reasonably be argued that the mechanisms for assessment should have been in place prior to a new system. However, at the time of writing some 4 months into MMC, new workplace-based assessments (WPBAs) for ST4+ are still being developed and piloted by the College. These will not, however, be able to address the inequity that will be felt by the new cohort of ST4 trainees next to their immediate predecessors.

These examples highlight a slippery slope that should concern all psychiatrists: service provision appears to be trumping substance in training. Long term, this risks predictable detriment to the service through lower quality consultants. There appears to be no evidence that sacrificing training to service will improve the latter. Tooke has been highly critical of MMC and has alluded to falling Certificate of Completion of Training (CCT) standards (and hinted at introduction of a sub-consultant grade). This is surely not what MMC should be striving for: this cannot be good for psychiatric training or for our patients, or for the new Dean's drive to improve recruitment to psychiatry.

Conclusion

This radical surgical excision is a cut too far and a solution implemented inequitably under MMC in response to a debatable problem. A more thoughtful approach would have been to preserve and nurture higher training opportunities; gather evidence of quality training in research and clinical specialties; and develop and validate novel outcome measures for special interest sessions/research days appropriate to higher training. Any implementation of changes should occur gradually over the coming years and in collaboration with psychiatric trainees. We look forward to quantification of training-post quality when the Psychiatric Trainees' Committee survey is published.

The Dean's insightful comment on the deprofessionalisation agenda crystallises the issue: '. . . a question that urgently needs to be addressed is – how do we train trainees to deal with complex cases when they may have limited time and opportunity to do so?'[23] The Tooke report and statements from other Medical Royal Colleges recognise specialty-specific needs, in contrast to the apparent push under MMC to homogenise all specialties. We must continue to recognise the higher training needs specific to an evolving specialty like psychiatry. The Royal College of Psychiatrists, which is world-renowned for educational quality, has an opportunity to reaffirm its commitment to excellence in higher training. The rationalisation of training under the guise of reform needs to be remedied urgently, or the quality, richness and purpose of higher training will be lost, to the detriment of patient care.

Declaration of interest

Both authors are Higher Trainees in London. G.J.L. writes in his personal capacity as a co-opted member of the Psychiatric Trainees Committee.

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