editorial

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Our educational future: a personal view†

Times change; the College is a very different animal from that first conceived in its Royal Charter of 1971. Gone are the days when we could sit back and expect everyone to fit in with the view from 17 Belgrave Square. The price of government interest – through the NHS Plan, the National Service Framework, a National Director and the promise of new money – is government interference. In reaction, the College has become a political machine, operated alongside sister organisations representing professionals, managers, patients and their carers. And the same is true in education, but here we have been more proactive.

There were those who saw the advent of the Postgraduate Medical Education and Training Board (PMETB) as the end of the world as we knew it. Personally, I found it astonishing that the government had taken so long to break the closed circle of Medical Royal Colleges (who lay down educational standards, inspect training schemes and set examinations) and the Specialist Training Authority (who take recommendations from the Colleges about who shall be admitted to the Specialist Register, and on which the College Presidents sit). Long before PMETB was ever a twinkle in the Minister's eye, our College was wanting to make changes that were frustrated at every step.

We had some key questions to ask ourselves. How is it that the number of medical students going into psychiatry remains fixed at around 4% when so many at medical school entry appear to be ideal recruits? Why do 50% of our trainees in psychiatry never reach consultancy? No matter how much we improve it, why does our exam-based system fail so many good doctors and pass so many poor ones? Why do we commit trainees so early in their career to sub-specialisations from which there is no escape? Why do we produce some consultants who know a lot but can't talk with patients or listen to their carers? Why do so many consultants get out at the first opportunity? Clearly, the system was satisfying no one – not politicians certainly, but not patients and carers, who bemoaned the lack of communication skills; not managers, who felt we were producing consultants too narrow and inflexible for services; and not psychiatrists, who we struggled to recruit and retain.

In this climate, whatever we think about the shambles of its first year, PMETB is a breath of fresh air. Now we have the opportunity to turn thinking on its head and start with the patient's, rather than the College's, interests. What sort of consultants do patients and carers need and how do we design a training system to produce them? And that, of course, fits in with the 'New Ways of Working' initiatives that are trying to get consultants back to in-depth therapy with a smaller load of complex cases and consultancy, in its proper sense, to other disciplines within multidisciplinary teams. And all that will be backed by Article 14, to be introduced along with PMETB, which will allow us to judge entry to the Specialist Register and substantive consultant posts on the quality of skills and experience in the field, rather than just exam qualifications.

So how will all this be implemented? On four key principles and the structures to fit them. First, patient-centred reforms: lay members have a strong presence on PMETB and its committees; they will almost certainly take part in accreditation visits; and the College has committed itself to using patients and carers in the training of all psychiatrists.

Second, a continuity of view: despite the difficulties of coordinating the overseeing bodies of the universities, the General Medical Council and PMETB, the College is determined to take a comprehensive view of training from sixth form in school, through medical school and the two postgraduate foundation years, to specialist psychiatry training, early consultancy and beyond.

Third, a core competency basis: we may not be able to offer enough pure psychiatry posts to soak up the number of juniors wanting a taste of psychiatric experience in the two foundation years, but we can develop slots within general medicine, surgery and accident and emergency that will spread a psychological approach. Such competencies as communication skills, team leadership and crisis resolution may be better monitored within psychiatry training by modular assessment of fitness to proceed rather than by examinations.

Fourth, flexibility: the aim of all this is not necessarily to shorten training but to keep options open at every stage. We might well end up with one general psychiatric certificate of completion of training (CCT), with a multi-layered specialisation and supra-specialisation thereafter in a pick-and-mix scheme that allows psychiatrists to develop more than one string to their bow. Also, we might be able to use continuing professional development

†See related papers, pp. 43–45; 46; 47–48; 49–52; this issue.

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(CPD) to allow consultants to change tack as patient needs, services and their own interests dictate. In other words, training opportunities continue to be offered throughout our professional careers.

What follows in this issue of the *Psychiatric Bulletin* are papers that put flesh on this skeleton of ideas. How the whole body will look when it is finished, I don't know. I understand how difficult it can be to live with uncertainty; but its development will be creative, exciting and far outlast me. It almost makes me want to start all over again!

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