doctors may be concerned about their failure to make progress in their careers, and these doctors in particular should be offered formal career counselling.

(3) *Statement about careers advice and counselling*
A statement should appear in the contracts provided by regions for their junior staff. This is in line with the proposal in the Report *Achieving a Balance*. Examples from two regions are included in the Report on the development on counselling being issued through the Standing Committee on Postgraduate Medical Education and Training, on behalf of the Committee of Postgraduate Medical Deans (1989).

(4) *Information requirements*
There is a need to co-ordinate and disseminate information about postgraduate medical education for providers, District Clinical Tutors and Postgraduate Deans as well as for doctors-in-training. Postgraduate Deans recommend the regular production of a formal newsletter or journal on medical training in the National Health Service. The newsletter or journal should have an editorial board consisting of Postgraduate Deans and others concerned with postgraduate medical education and should be produced by the Department of Health. It could contain reviews about training for particular careers and the provision of facilities for postgraduate medical education, as well as articles about original approaches to postgraduate medical education, including medical audit and the assessment of trainees. It could become a useful resource for information about training requirements of colleges and faculties, as well as for bulletins from the Department of Health.

(5) *Development of training related to counselling*
Increasingly, Postgraduate Deans are involved in promoting the educational strategy for management in their regions. Several important educational approaches can be introduced through management training, including techniques for training juniors, development of counselling skills and the way in which they may be helped to develop their careers.

The development of more adequate career advice and guidance for doctors in training will require a more reliable data base on doctors in training and also about the posts. Maintenance of records of all training that is taking place and the posts will be a major requirement for counselling programmes to function satisfactorily. A number of regions are already developing such programmes, using their manpower systems as a base. All regions will require such systems to be capable of co-ordination as doctors move between posts in different regions.

Some psychiatrists in training may point to overstaffing in training posts and difficulties that exist for particular individuals. It is easier for a non-psychiatrist, as I am, to point to problems which have recently concerned me in another discipline. An appointment committee for two Senior Registrars in surgery in the Oxford region, had 62 candidates to consider and 6 were short-listed. Of the 62 candidates all had fellowships and towards a half already held, or were about to submit for a higher degree. Many were approaching their late 30s. Such doctors are being frustrated in their careers. Some may not make consultant posts, and it is not surprising if their interest in continuing education, research and the future development of their professional experience become stultified by years of waiting. Postgraduate Deans are trying to develop the systems which will assist all doctors in training posts to achieve their full potential in reasonable time.

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Career counselling and women doctors

Ilfra Goldberg, Deputy Dean of Postgraduate Medical Studies, University of Manchester and North Western Region

The career pathway of men and women doctors has been examined in a detailed report from the Policy Studies Institute (Allen, 1988). All doctors said that there had been very little careers advice and counselling available at medical school or while in training grades. Most women doctors thought that there should be careers information directed specially at women, with the general understanding that career pathways of women were likely to be disrupted to a variable extent by family commitments.

There are now equal numbers of men and women entering medical schools, and it is estimated that by the year 2000 women will occupy about 40% of the NHS medical manpower posts. Over 80% of women

doctors have children, and this is likely to cause some degree of interruption to their career pathways.

Many women doctors aim to complete their postgraduate training and take up a career post with a full-time commitment throughout. A small group of women doctors may leave medicine altogether, or retain a minimum contact only with the profession. Others wish to continue postgraduate training, but on a part-time basis while their children are young. This group generally expects to return to full-time training or to a full-time career post when their domestic circumstances permit.

A major task for those responsible for counselling women students and young women doctors is to inform them of the opportunities in the different specialties, and of the possibilities and implications of part-time training. About 75% of all doctors interviewed in the recent survey (Allen, 1988) had not heard of part-time training, and even among women doctors, 68% did not know that part-time training is a possible option. Planning of careers combined with family commitments is being undertaken without full knowledge of the options in many cases.

The main difference in the careers advice for men and women is the provision of information and guidance on part-time training required by women doctors. Men with domestic commitments are also eligible for part-time training, but at the present time the number availing themselves of this opportunity is very small.

Provision of part-time training posts has been recommended for many years (Royal Commission on Medical Education, 1965–68; Rue, 1967), and there is now the PM(79)3 scheme to provide for part-time training in all grades, and in all specialties. The patterns of provision and use of this scheme vary considerably from Region to Region, and depend on policy decisions by Regional Postgraduate Education Committees, and on the constraints by Regional Health Authorities. This variation in opportunity makes it difficult to advise women doctors accurately, and difficult for them to plan their careers and family arrangements.

Trainees considering part-time training will wish to be informed further in certain areas relating to the part-time scheme: the establishment of the post; that the quality of training is recognised as being equivalent to that of full-time trainees; the effect of a period in part-time training on their chances of returning to a full-time post in the National Health Service; the outcome, in terms of career posts for those in part-time training; and whether some specialties are more appropriate than others for part-time training.

Part-time training posts are usually supernumerary to the existing established posts, and are created on an *ad hominem* basis. At Senior Registrar level there is competition on a national scale for posts in each specialty, and the posts allocated are accounted for in manpower planning. At Registrar and SHO grades the numbers involved are small and posts are currently established at regional level. There are proposals now put forward to organise the appointment of part-time Registrars on the same principles as apply to part-time Senior Registrars, with competition for posts, and for posts to be within set quotas. Training programmes are drawn up in consultation with the consultant trainers and the individual concerned, and should provide the same sort of training as full-time trainees receive, and should include *pro rata* study leave and research time, and on-call experience. The College, or regional training committee gives educational approval to the post. The Postgraduate Dean is responsible for ensuring that the trainee makes satisfactory progress, and that she is reviewed and counselled when necessary. If the post-holder is properly monitored she should be in a good position to apply for full-time posts in the NHS in due course. The successful outcome of part-time training depends on the scheme being seen to provide a creditable alternative to full-time training and on the trainees successfully competing for career posts with their full-time counterparts. There is a drop-out rate in all grades even in full-time training, and inevitably not all part-time trainees will be successful. The failure rate should be kept to a minimum, and this can be achieved by effective counselling before a post is created, and periodic review of the progress of the trainee while in post.

Some specialties have more part-time trainees than others. Some specialties like psychiatry, anaesthesia, or pathology which until recently were shortage specialties, were seen as areas of opportunity for women wanting to train part-time when part-time training was less well established than it is now. Such specialties have developed the necessary expertise in setting up and monitoring part-time training, and may attract women into the specialty because of this well recognised opportunity. The Royal College of Psychiatrists (1984) in particular commissioned a study of the career pathways of trainee psychiatrists both full-time and part-time. In surgical specialties there are few part-time posts. There is a belief among some consultant surgeons that the intensity of experience required in surgical training does not lend itself to training on a part-time basis. It may also reflect the very competitive nature of a career in surgery. Women need to appreciate these problems before embarking on a career in surgery.

Difficulties encountered by women doctors in their career pathways reflect widespread anxieties among all trainees about their training, and prospects at the end of training. The gradual implementation of *Achieving a Balance* (1987) may lessen these difficulties, and should enable better counselling to take place.

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Specific counselling needs of psychiatrists

DAVID STORER, Consultant Psychiatrist, The General Infirmary at Leeds, Associate Dean of Postgraduate Medical Studies, University of Leeds

Good counselling requires the development of the capacity to listen. What follows is what psychiatric trainees, including consultants, have told me of their counselling needs. I am grateful, therefore, to my own trainees both past and present and to a large number of psychiatrists in the Midland Division of the College who have taught me about the difficulties of psychiatrists in training during my visits to them as part of the College Approval process. Dr Ray Haddock, who has carried out a survey of trainee psychiatrists in the United Kingdom (Haddock, 1987), has been kind enough to discuss his findings with me. For the past year I have for half of my time been Associate Dean of Postgraduate Medical Studies in the University of Leeds and have begun to place my observations of psychiatric training in a wider context.

Psychiatrists may have different counselling needs because they are different from other doctors by personality and inclination. There is some evidence for this and certainly it is true that doctors, medical students (Harris, 1981) and probably the general public believe that we are different. My own impression is that these differences have been exaggerated and that the problems of a medical career are surprisingly similar between specialties.

Difficulties specific to trainee psychiatrists can be loosely categorised into three groups:

(1) *Career difficulties*

Trainees in all hospital specialties need to pass postgraduate examinations. Most psychiatric trainees do not need or seek counselling about examinations. A minority, however, have not passed after several attempts and become concerned about how to succeed and why they have not done so. Some training schemes allow doctors to take a long time over taking examinations, much longer than would be allowed in most other specialties. This is no kindness to trainees who even after passing the membership may well be at a disadvantage at interview for senior registrar posts compared with candidates who have moved rather more quickly. It is often those candidates who have taken some time to pass the membership examination who have no completed research to demonstrate on their CV on applying for a senior registrar post and they become even less likely to be appointed and correspondingly more likely to be regarded as "stuck doctors". Although there are now guidelines for counselling stuck doctors, it is not clear where they will go in psychiatry. Staff grade posts are being created but probably not in sufficient numbers.

Achieving a Balance has created particular insecurities in trainee psychiatrists, partly because of the blurring of the SHO and registrar levels in many psychiatric training schemes. Current SHOs are now concerned as to whether they will obtain registrar posts. Some registrars are apprehensive of new regional and sub-regional rotations, fearing that they may not be accepted on them and that the best training posts will be lost to existing schemes.

(2) *Patient management issues*

Doctors entering psychiatry are confronted by management styles and aspects of decision making which are quite different from those they will have experienced before.

On a rotation scheme they may change in quick succession from a team working to a multi-disciplinary model where little is expected of an SHO to one working on traditional medical lines where the doctor is expected to make the decisions. Many find this a stressful transition.

Psychiatry is the only specialty where patients are regularly treated against their will. Many trainee psychiatrists find this unpleasant and they require clear guidelines as to their role in administering the act and support in doing so. Section 5(2) is a particular cause of concern in some hospitals.

By the time doctors enter psychiatry they are familiar with dealing with the death of their patients. They will, however, be unlikely to have experienced the stress of a patient dying by his or her own hand. Suicide is an unpleasant event to even the most experienced psychiatrist and it is, perhaps, because of this that counselling and discussion of such cases is not as full or frank as it could be (Rossiter, 1989). Attempted suicide can pose different problems particularly when, as is sometimes the case, doctors are allowed to see large numbers of parasuicide cases without the supervision one would expect, for example, in the out-patient clinic.