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culture of collaboration and joint ownership of the academic programme that would direct the current arrangements to produce a more coordinated, protected and rewarding training experience. The CAPSAC could facilitate exchange of good practice between schemes, standardise the appointment and training of coordinators, and place pressure on trusts to release coordinators from clinical commitments to allow them more time for the academic programme.

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Declaration of interest

None.

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Talking together. Commentary on . . . Higher specialist training in child and adolescent psychiatry[†]

It is very encouraging to see trainees who are so enthusiastic about training that they are prepared to persist despite considerable barriers to carry out this type of audit. Hawkins *et al* are to be congratulated for raising these issues, especially at a time when postgraduate medical education is undergoing a revolution, and it is essential that we consider all the evidence available in planning future higher training curricula. I am particularly pleased because the issues raised in this paper have been considered at some length in the course of various meetings of the Royal College of Psychiatrists' Child and Adolescent Psychiatry Specialist Advisory Committee (CAPSAC), with many of the same solutions proposed here put forward.

It seems that most of the issues raised within this paper could be subsumed under the broad heading of communication: between CAPSAC and programme organisers through the advisory papers; between programme organisers and trainees; and between CAPSAC and managers through the written reports generated by accreditation visits. As psychiatrists we rightly pride ourselves on our excellent communication with our patients. How then can we make sure that the same skills are used to talk to each other?

CAPSAC and programme organisers

The CAPSAC advisory papers are written to provide guidance to those involved in running higher training

programmes and to allow trainees to assess whether or not the training that they are being offered is consistent with what the College recognises as adequate experience for the training of future consultants in their specialty. They are deliberately written so as not to be prescriptive. The wide range of training schemes across the country precludes standardisation and CAPSAC has never believed that standardisation of training is necessarily a laudable goal. The richness delivered by our variety is one of the things that attract people to child and adolescent training despite the fact that it is somewhat at odds with the current dogma of centralisation and sameness.

The advisory papers written in 1999 (Royal College of Psychiatrists Higher Specialist Training Committee, 1999) are in need of updating, but a decision has been made not to undertake this challenging task until we have greater clarity about the shape of future run-through training. This does mean that advice about training has not moved on as quickly as the demands of organising a scheme. The advisory paper on academic programmes does not specify the content of such programmes in detail. With the knowledge base in child and adolescent psychiatry expanding so rapidly, it would be foolish to try to delineate this too clearly. The publication of the advisory papers on the College website is a start in the wider communication between the committee and the faculty, and CAPSAC has also investigated the possibility of publishing academic programmes from schemes across the country on the website to enable better information

[†]See pp. 19–23, this issue.



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sharing. This is something that would be welcomed by trainers and trainees alike. The CAPSAC would therefore wish to encourage the College to expand the use of the website to disseminate good practice in training.

Trainees and programme organisers

Partnership working is one of the key themes of the modern National Health Service and it would seem obvious to suggest that we ought to be able to do this within our own training schemes. Within our specialty we are immersed in systemic practice and should be able to apply these principles to ourselves. The CAPSAC certainly encourages the formation of training committees within schemes, which should include trainee representation. Such committees enable better communication within schemes and can provide a forum for evaluating all aspects of training, including the academic programme.

It is seldom possible to meet everyone's needs within one academic programme. The challenges of producing a 3-year rolling programme that is up to date, of high quality, accessible to all trainees and (usually) free are formidable. Virtually all these programmes run on a grace and favour basis with very limited resources. Although this might be deplored, it unfortunately represents the reality of much of medical postgraduate education. It remains to be seen whether or not the advent of the Postgraduate Medical Education and Training Board (PMETB) and Modernising Medical Careers will change this. Meanwhile it behoves all of us to work together to deliver quality education. This is time-consuming and often not programmed into job plans.

CAPSAC and managers

One of the real pleasures of undertaking accreditation visits is the opportunity to see 'how other people do it'. It gives one the chance to ask outrageous intrusive questions and to take a rigid position on things which, within one's own service, one may be more flexible about. This

can often apply to the issue of protected time for training programme directors and others with a semi-formal role in delivering training. There is no doubt that the advent of the new consultant contract has brought these matters into a sharper focus than previously.

A recent audit that CAPSAC carried out with training programme directors revealed that 3 out of 19 directors had no protected time in their job plans for organising their training scheme. Since separate organisers of academic programmes are not formally recognised by the College, it is hardly surprising that they have little protected time. This is not to say that CAPSAC believes that this is a desirable situation.

Recommendations in accreditation visit reports frequently contain statements about the necessity for programme directors, and indeed all trainers, to have adequate time to devote to training. However, CAPSAC is an advisory committee and employers are not obligated to act on these recommendations. Again this is something that may change when PMETB has more responsibility for accrediting training schemes.

Despite our challenges with communication, I believe that we do all strive to work together to produce high quality training and excellent consultants in child and adolescent psychiatry. Like everything else we do, there is still room for improvement and I hope none of us yet feels that we can rest on our laurels. The challenges ahead are many and the lines of communication must remain open and effective.

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