size and complexity of the regional training scheme.

Content

As well as local tours given by local junior staff and information from the local clinical tutors about special experience available in their hospitals, the following seminars might be given: 'The Practical Administration of ECT' (at the 'model' ECT suite in the region); 'Interview Skills', 'Over-view of the Use of Psychotropic Drugs'. 'Library and Regional Facilities at the University Campus', 'Audit and Research Opportunities in the Region', and 'Cardiopulmonary Resuscitation'.

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Psychodynamic supervision for junior hospital doctors

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This paper describes a supervision group for senior house officers which focused on the psychodynamics of their working relationships with patients. The SHOs worked in a variety of hospital specialties as well as general practice. The description includes details of how such a group was set up and some of the practical difficulties in maintaining the SHOs' attendance. Brief details are given of the types of cases the SHOs were most eager to discuss, and the nature of the leading anxieties connected with the cases. The SHOs found this type of supervision supportive and enlightening as they developed and improved their clinical skills.

Junior doctors are expected to cope with the emotional turmoil that is engendered by their work, to face new clinical situations which can be deeply disturbing and yet to somehow maintain their own sense of psychic equilibrium. Emotional distress in junior doctors is common (Firth-Cozens, 1987; Hale & Hudson, 1992) and there is a clear need to provide them with more support and to help them develop personal skills in understanding and managing their own anxieties and those of their patients in a healthy and realistic way.

This paper briefly describes a psychodynamic supervision group that was set up for senior house officers from a variety of clinical specialties, at University College Hospital, London aimed at addressing some of these issues. Such supervision provided a forum for the junior doctors to learn about the nature of anxieties associated with illness and death, defences used in the face of these anxieties and the psychological work involved in mourning. It also promoted an understanding of the importance of containment and countertransference issues with regards the doctor-patient relationship. Although Balint pioneered models for general practitioners to learn more about psychological factors involved in their work (Balint, 1957), we have not read a description of a group which encompasses the work of junior doctors in different hospital specialties.

Setting up the group

The supervision group was established and run by a senior registrar in psychotherapy in the Department of Psychological Medicine at UCH. The original group members consisted of four senior house officers who had taken part in the Student Psychotherapy Scheme at UCH which gives medical students supervised experience of weekly supportive psychotherapy with individual patients. Three other SHOs joined the group subsequently who did not have this experience; two were introduced through their contact with the department of psychiatry. The SHOs worked in paediatrics, neurology, obstetrics, geriatrics, general medicine, psychiatry and casualty. Recently, three SHOs have moved into general

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practice. The timing and frequency of the group accommodated the working demands of the SHOs. The group met fortnightly at UCH from 6.00 to 7.30 p.m. This time was necessary because of conflicting ward routines, to allow members travelling time from other hospitals and to take into account conflicting rotas and holiday leave so as to encourage a minimum of three members at each meeting.

At the start of each group one of the SHOs would volunteer to present a patient he or she had recently been working with. The expectation was that the SHO was likely to discuss a case that had raised particular difficulties or conflicts. The doctor presenting would start by describing the circumstances surrounding the first contact with the patient, the nature of the complaint as it was presented and the doctor's early interactions with the patient and others involved with the case. The rest of the group would then be asked to share their initial responses to what they had heard.

They were particularly asked to address why they thought the case was being presented, to give their emotional responses to the material, and how they viewed the conflicts and dilemmas as they were described. The presenting doctor was allowed not to have to discuss his or her own feelings, anxieties or reactions to the case. The others were encouraged, rather than to ask direct questions of the presenter, to think about the phantasies that lay behind the curiosity that prompted their questions. The group could speculate about the patients' history and background before hearing more details. The supervisor would then attempt to help the group integrate the different contributions and viewpoints that each of the members had made in order to create a better understanding of the psychodynamics of the total situation surrounding the case.

Details of the cases

Twenty-six cases were presented over 18 months. Paediatric, psychiatric and general practice cases were most often presented, six cases in each specialty. Three obstetric, two geriatric, one neurology and two casualty cases were discussed. Ten of the cases centred around infants and children. Seven of the children were less than four years old and two 13-year-old adolescents were presented from child psychiatry. Of the adult cases, nine women were presented with an average age of 35 years and six men with an average age of 51 years.

The SHOs presented cases that they had never been exposed to before such as death of young children (3), severe physical deformities in adults and children (4), and suicidal patients (4). In these cases the junior doctor was often left with persecutory thoughts of being blamed for not doing enough and for not making good damage that was irreparable. The junior often found senior colleagues avoiding the families or infrequently visiting the wards and so felt left to deal with the burden of facing the parents, which they came to dread. Feelings of not having been good enough or done enough to prevent a child from dying often interfered with their own mourning of the loss.

Having to face the reality that their patients died was particularly difficult when treating children and they were often the most painful cases we had to listen to. These cases were more difficult when the parents could not accept the inevitability of the death. For example, one four-year-old child had been brought to London from overseas with the known diagnosis of an inoperable brain tumour. His parents had come to London with unrealistic expectations for a cure which did not materialise. Under different circumstances the medical team might have felt that they had done all that they could in trying to help, but instead were left feeling hopeless, useless and inadequate. The junior seemed vulnerable to feeling that he carried the burden of failure for his team.

SHOs could feel closely identified with their patients (3), especially those closest to them in age. Examples of this were two gynaecological patients, one a 26-year-old woman with possible cancer of the cervix and another an 18-year-old woman who underwent bilateral oophorectomy for a borderline neoplastic condition.

Fears concerning loss of fertility, damage to sexual organs and cancer involving the reproductive tract were distressing to bear. There was also an anxiety in the second case that the young woman had been passive to a very intrusive father who had pushed for surgery which had seemed invasive and mutilating. Although this was speculative, the supervision allowed exploration of these phantasies and for the possibility that doctors at times act on pressures they are not consciously aware of, not always in the best interest of the patient.

Another group of patients (4) the SHOs found difficult were when a child was presented as the index case but where severe psychological disturbance in the mother was apparent. In two cases Munchausen by proxy was suspected. These cases left the SHO confused, bewildered and not knowing what to do or how best to deal with the situation. Multiple agencies were usually involved, with splitting of the teams over the diagnosis and management and with no coherent plan of treatment able to be sustained. Suspicion and anger towards the mother for treating the child as if he had no feelings or separate existence interfered with making a therapeutic relationship. It was difficult for the

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team to address the mother's needs as a way of helping the child. The SHOs were left with many unresolved questions and conflicts and a feeling of hopelessness and despair for the child's future.

Patients with overt psychological disturbances were commonly discussed, three from psychiatry, three from general practice, one from neurology and geriatrics. The three general practice cases presented with somatic complaints and made the SHO feel confused, "he mixes me up", or angry. It was a difficult task to be made by the patient to relate only at a bodily level (for example, "the man with the red nose") and even when the SHO tried she was made to feel useless as a doctor or that she was missing the point. This was also true for three psychiatric patients who presented with depression and who induced intense feelings of anger and ambivalence, not only in the SHO but in many members of the team. Supervision allowed exploration of the underlying psychological conflicts and how these patients had a powerful ability to idealise some people and denigrate others.

Conclusions

This group had the advantage of starting with several members who were psychologically minded and who knew each other. The SHOs continue to attend on a regular basis despite busy work schedules and exams. They have appreciated a forum for discussion and containment of their own anxieties aroused by their contact with patients. They are learning to better recognise that patients can induce very powerful affects in them that can be defensive, a form of communication, a way of getting rid of unwanted feelings or even be a form of aggression. It has been particularly encouraging that this form of supervision has been able to encompass so may different hospital specialties, as well as general practice cases, in the same group. The authors think that it is a model that could have wider application for teaching medical students and junior doctors about the complex psychodynamics involved in their work.

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