Role conflict and barriers to learning for senior registrars in child and adolescent psychiatry

D. M. Eminson and J. M. Green

The landscape of training in child psychiatry is changing fast. In recent years the content of theory and practice within the discipline has evolved rapidly and the latest Royal College guidelines for higher training (Royal College of Psychiatrists, 1995) show a daunting array of training areas to be encompassed in four years or less. The Calman proposals (Department of Health, 1993) will abbreviate and so inevitably further intensify postgraduate training in the speciality. We argue in this paper that the fact of entering such an intensive training at the level of senior registrar can, under certain circumstances, create barriers to learning. We describe the efforts of trainees, consultants/trainers and scheme coordinators to adapt to these difficulties as they arise.

Role conflict for the trainee

In all hospital specialities doctors entering the senior registrar (SR: in future specialist registrar, SpR) grade will be experienced clinicians, often in their thirties. Unlike most specialities, the newly appointed SR or SpR in child and adolescent psychiatry is not required to have had any experience of the speciality. Even in the most recent College guidelines, six months in child psychiatry is only recommended (Royal College of Psychiatrists, 1994) and we find a decreasing proportion of recruits have prior experience in postgraduate paediatrics. This contrasts starkly with the level of relevant experience possessed by most registrars in other medical specialities at this career stage. In any branch of adult psychiatry, three years' adult experience would be a minimum; in paediatrics, six or eight years is common.

Central to the difficulties we describe is the potential conflict between clinical and personal maturity in comparison with lack of experience within child and adolescent psychiatry. Under some circumstances, we believe this can set up a role conflict, that can at best cause discomfort and at worst be a barrier to effective learning.

Some aspects of earlier training are of course transferable. Theoretical knowledge of psychiatry apart, skills in managing adults with a psychiatric illness may transfer to work with parents and psychotherapeutic training may assist in many areas. On the other hand, clinical work with the younger child and adolescent and with families can be initially bewildering. The wide range of thinking that has to be done in biological, psychological and social realms, the systemic conceptualisation, extensive multiprofessional working, and the different legal framework are all unusual in other areas of psychiatry. The extent of their unfamiliarity is likely to strike trainees in any clinical setting for children and adolescents. However, the more acute and demanding the clinical problems, the more complex the working teams and the more these differences may be intensified. We have found that it is in the in-patient and day patient setting that these problems often come to a head. Such units are giving total care to often highly disturbed children and families. There are multiple potential sources of clinical pressure arising at any time from a number of groups such as the child group on the ward, the staff group or the school. The clinical teams are large and great attention has to be paid to communication: the SR is often seen as having a critical mediating role in this complex situation.

Defences to learning

Novice SRs and SpRs may respond to this demand in a variety of ways, some of which can be maladaptive.

Bewilderment and fatigue

While understandable, even this is difficult to express. The peer group may include a senior house officer and registrar, who will look to the SR to provide higher levels of competence with children, informal supervision and advice. It is hard to acknowledge that one is senior and yet feels so incompetent. Trainees describe knowing

https://doi.org/10.1192/pb.21.6.339 Published online by Cambridge University Press

that they are gaining good experiences, but being unable to think about or process them.

Denigration of the placement

Blame may be laid upon the institution (morale is low, the staff are demoralised), upon the consultant (not supportive enough, has missed supervision on occasion), on the workload or the type of cases (too much abuse and parenting failure are upsetting and unfair on junior doctors).

Denigration of clinical training, while demanding 'proper' therapeutic training in settings outside the clinical placement

Medicine has traditionally used an 'apprenticeship' model of the trainee learning while working within a specific service. We see the primacy of this model as having been challenged in a number of ways recently: the formalisation of training schemes provides separated protected space for research; there is a powerful trend towards formal courses (with qualifications) in a number of therapeutic techniques and the structured containing experience of such courses can compare favourably with the hurly burly of clinical placements. Difficulties of learning within a clinical placement can thus make these alternatives seem more attractive at the risk of undermining the core integrative function of clinical training.

Pseudo-maturity

Stressed and anxious senior registrars may, at either a conscious or unconscious level, seal themselves off from overwhelming demands by developing a facade of confidence. This may have a number of consequences. One is an overly rapid decision-making process and a reduction in the ability to acknowledge inexperience and uncertainty. There may be a decline in requests for help or guidance with an impression of confidence and impatience with the trainee role. This 'competence' is brittle and can alternate with overwhelming anxiety and a need for urgent unplanned supervision time. Planning for the future can be affected, expressed in an urgency to achieve consultancy.

Inability to use supervision time profitably

The weekly supervision meeting becomes uncomfortable when the trainee is feeling highly critical, over-burdened or is 'pseudo-mature', the latter particularly giving confusing messages to the trainer. The normal relationship in supervision, which usually includes elements of dependence that gradually diminish as the trainee gains experience, can be replaced by a fluctuation between over-confidence and neediness. Tense and dysfunctional supervision makes it difficult for the trainee to discuss his or her own feelings and leads to further emphasis on case management as the focus, at the expense of more general professional or training issues. The further this process continues, the more difficult it is to discuss the problems of supervision or the placement.

Collapse and *despair* together with repudiation of child psychiatry as a career is another disastrous possibility.

The trainer's dilemmas

There are potential conflicts for the trainer which mirror this role conflict for the SR and which may exacerbate the situation. The traditional structure of training within the apprenticeship model tends to lead to considerable clinical autonomy and responsibility at the SR level in typical teaching hospital practice. The inexperience of SRs in child and adolescent psychiatry means that consultant trainers have to modify this structure. When service demand is high, this can come into conflict with training responsibilities and for consultants, delegation of clinical work may imperceptibly become a part of their mechanism of coping. Under clinical pressure, training tasks sometimes come to be performed mechanically. Perhaps a good marker for this is when the weekly supervision sessions become over-concerned with clinical management issues at the expense of training and process elements. The trainer also experiences discomfort when the difficulties outlined begin to disturb the relationship in supervision. This too may be difficult to acknowledge. A general change in the style of training and the need for trainees' roles to be technically 'supernumerary', has combined with greatly escalating clinical and time pressures. We know many consultant colleagues in different disciplines with similar concerns.

Possible remedies

What can be done to anticipate these difficulties and ensure that clinical placements within the apprenticeship model fulfil their role?

Awareness

Clearly, becoming aware of the dynamics of the problem is necessary. A combination of large structural changes and varying local pressure impinge on each trainer and trainee. We have found that the most useful aid to awareness has been the opportunity for the whole group of trainers and trainees in a scheme to meet both separately and together to discuss their

https://doi.org/10.1192/pb.21.6.339 Published online by Cambridge University Press

experience and current issues. The group of trainers has had, on occasion, outside facilitation and the investment of both time and money into this has been worthwhile. Medicine has traditionally been weak on training trainers: both theoretical and experiential training can greatly improve awareness and confidence.

Controlling workload

The complex task of balancing clinical and teaching roles within a service needs a controlled workload. The multiple sources of work pressure within day-patient and in-patient units make them perhaps particularly vulnerable here. Trainer and trainee need to agree a sensitive system of feedback about the workload. This can be particularly difficult for the conscientious trainee who observes service pressure and for the experienced trainee testing him or herself against complex problems for the first time. Although it seems mechanical we are increasingly predetermining the number of cases at various levels of complexity that trainees will undertake: when they have reached this quota they take no further referrals for a time. Eventually this also encourages service rearrangement: for example, training non-psychiatrists to undertake risk assessments prevents juniors being overwhelmed by overdose assessments.

Support for the consultant as trainer

The consultant has the difficult task of respecting and trusting junior doctors' seniority and experience as clinicians while nurturing their vulnerability and anxiety as novice specialists. Each trainee will have an individual mix of needs. The trainer can only respond appropriately and sensitively if his or her roles as clinician on the one hand and trainer on the other are not in conflict. Support for the consultant's clinical role needs to come from other senior staff in the unit but also from the institution; increasingly specified contracts may help. Support for the consultant's trainer role from the scheme coordinator is also vital. We have found that regular trainers' meetings as a group, but also 'trilaterals' with scheme coordinator, trainer and trainee during the placement, can be invaluable.

The scheme coordinator's role

The scheme coordinator observes the effect of certain placements on many individuals, and monitors changes in morale in the group of SRs and trainees over a longer period. The coordinator must be trusted as an advocate for the trainee and regular reviews are essential. If the coordinator observes the learning defences to be erected more frequently by trainees over time, consideration must be given to the likelihood of a systemic problem, rather than one trainee or one trainer being troublesome. The systemic problem may be within one clinical placement, but we suggest the wider system of higher training may be contributing. Thus, in addition to supporting trainers and trainees, the scheme coordinator must raise these issues at the level of College training committees.

Structuring the training

Structuring the clinical training through the use of log books and standardised expectations for each placement is developing in most schemes, including the one we describe. These can create pressures of their own, not least in the extra administration for everyone, but they do help thinking about training. Even more relevant to the dynamics we are describing here would be an induction period for higher trainees and trainers in which problems of the kind we have discussed are explicitly identified. The College also has a role in monitoring training through regular visits by representatives of the Child and Adolescent Psychiatry Specialist Advisory Committee (CAPSAC).

Conclusion

The late post-membership entry into child and adolescent psychiatry training can cause a conflict between the learning and clinical roles for doctors, particularly in situations of high clinical pressure. In this speciality the problem is compounded by the increasing complexity of the subject to be learned and the reduced time in which learning takes place. The apprenticeship model of training within clinical settings must adapt to prevailing conditions in order to retain its central place in medical training.

Practice points

(a) The effects are most likely to show themselves first in high demand settings such as in-patient and day-patient units.
(b) The workload for trainees in clinical teaching environments must be kept within guidelines.
(c) Increased awareness of potential problems in learning can be helped by regular meetings for trainers on a scheme, as well as trainees and joint trainer/trainee meetings.
(d) Programmes of training for trainers should be further developed and taken seriously: training in supervision issues should be included.

https://doi.org/10.1192/pb.21.6.339 Published online by Cambridge University Press

(e) Support for trainers, including regular meetings and trilateral meetings between trainer, trainee and scheme coordinator, can be helpful.
(f) An induction discussion identifying potential difficulties in learning as well as the use of log books and explicit objectives during placements may be useful prophylactics.

Acknowledgements

We would like to acknowledge the help that the SR trainees in Greater Manchester have given us over many years to come to some understanding of these issues. Special thanks to Lucy Gannon and Malcolm Bourne for their contribution.

References

DEPARTMENT OF HEALTH (1993) *Hospital Doctors: Training for the Future*. The Report of the Working Group on Specialist Medical Training (Calman Report). London: HMSO.

ROYAL COLLEGE OF PSYCHIATRISTS (1994) *Statement of Approval of Training Schemes for General Professional Training for the MRC Psych*. London: RCPsych.

— (1995) *Handbook of the Joint Committee in Higher Psychiatric Training* (7th edn). London: RCPsych.

*D. M. Eminson, *Consultant Child and Adolescent Psychiatrist, Child and Family Services, Bolton General Hospital, Minerva Road, Farnworth, Bolton BL4 0JR; and* J. M. Green, *Senior Lecturer, University of Manchester and Honorary Consultant Child and Adolescent Psychiatrist, Booth Hall Children's Hospital*

*Correspondence