Consultant at Large: The First Year Reviewed

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(In the Spring 1981 Peter Hardwick left his post as senior registrar in child psychiatry in London to take up his first consultant appointment—as Child and Adolescent Psychiatrist to Wessex Regional Health Authority.)

For that first day, just over a year ago, I had had my grey, slightly pinstriped suit dry-cleaned and bought new shirt, shoe laces and after-shave to emphasize a fresh start. As I drove up to the clinic (somewhat early), I weighed up the pros and cons of the job I had accepted: pros—nice part of the country, relaxed life-style, pleasant people; cons—rather professionally isolated, no university, no in-patient unit (or was this one a pro?).

All these thoughts left me as at the designated time I took the plunge and entered the clinic. I suddenly felt like a principal actor about to go on stage for the first night, sure of his lines (rehearsed over the past three years), but unsure of the part. The initial pride in seeing my name painted on my consulting-room door rapidly evaporated as, alone, I perused one of my first referrals—a female homosexual couple bringing up two male teenagers showing a jungle of weird psychopathology not mentioned in my well-worn copy of Rutter and Hersov's *Child Psychiatry*. I was reminded of the paintings of Salvador Dali. Are all the referrals going to be like this one? For a ridiculous regressed moment I thought I must discuss this one with my consultant. Then my mind was shocked into anxious super-cerebrations trying to produce both references and interventions, the former mental activity being in the habit of the place from whence I had just come. My mental fugue was fortunately halted by the timely arrival of my secretary who reminded me that, by instruction, no cases had been booked for this first week as instead arrangements had been made for me to meet team colleagues and other key people in my professional network.

'How do you work?' 'Do you use co-therapy or drugs?' 'How do you see yourself liaising with social services?' These questions were asked of me for the rest of the day. I soon realized just how much my 'part' would be open to improvization. The freedom of what I could do suddenly appeared limitless and my feelings of omnipotence rose to a point where I felt them to be out-stripping my experience and then self-doubt enveloped me. It was as though overnight everyone had started regarding me as much older and infinitely competent and experienced. I remembered some advice on not committing oneself to anything too soon and not worrying about making an immediate good impression, as one has (hopefully) 25 years or so to build up both the service and one's reputation, and so my replies became non-committal.

After London, the view from the clinic of the Georgian market town and countryside that was to be home was most distracting. The novelty of the view and its magnificence made me wonder if it was real or merely some backcloth behind which hid Battersea Power Station. By lunchtime I was only too eager to leave the clinic and go out and explore. Perhaps the surfacing of another less desirable feeling that I might well be shackled to this job for the rest of my life led me to regard with particular interest the perfectly preserved town stocks located in a park within view of the clinic. Manual exploration of the stocks resulted in panic as I felt my wrist to be caught in the hole. Important people I had just met suddenly seemed about to pass by or watch me from the clinic. The relief on the release of my hand did not detract from the efficacy of the incident in acutely reminding me that I had come down here to enhance the normality of the region!

Soon the first few weeks had passed during which I confirmed that, in my case, one cerebral hemisphere remembers names and the other faces and there is no connection between the two. Families came and went, day-in, day-out, leaving my mind juggling to fit names to faces. My pin-striped suit was downgraded in stages through corduroy to more comfortable sports jacket and flannels. Rapidly my fresh, new diary was filled six weeks in advance, apart from one afternoon a week which I resolved to keep free for very urgent cases (psychiatric arrests, as a medical colleague reflected).

Any aspirations of doing anything like a full Maudsley history and intake procedure before choosing a treatment mode were rapidly dispelled by the sheer pressure of clinical work. Short cuts were necessary and indeed indicated for many cases. The most effective one has been to begin working straightaway with the family relationships. Here I have found my family therapy training invaluable. Out of expedience I have also used, more than hitherto, straight advice to surprising effect at times. Surprising because I have had to re-edit a myth that all patients resist advice (based on much experience of cases where the case notes weighed nearly as much as the entire family!). I started dreaming of fantastic solutions to the massive clinical demands such as hiring an auditorium and doing therapy with all my families en masse.

In those first family sessions it seemed as if everyone—both families and new colleagues sitting in with me—was expecting me to produce an all-embracing, mind-shattering intervention that would create psychic heaven all round. In actuality, families were somewhat astounded to be the

recipients of directives to talk to each other, change seats, etc., and colleagues worried that when we took a break and left the room to plan strategies, the family might murder one another or commit mass suicide. In the past I had always been kept in check or supported by colleagues, but now the overall lack of feedback from my new colleagues, who were, as yet, unused to my way of using trendy, active family therapy techniques, left me feeling insecure in my approach, despite my training. Also, at first, there was something rather special and fragile about cases for which I had total responsibility. In my professional isolation I suffered nightmares that none of my clients would get better and that I was becoming so idiosyncratic that I would awake to find the three wise men or the entire GMC assembled at the foot of my bed.

Waiting for a family to arrive when the previous session had been dramatic and action-packed was like awaiting exam results. Fortunately I was greatly helped by invaluable support from my colleague child psychiatrist, also relatively new and of similar orientation.

As the weeks flew past, my fears of increasing eccentricity diminished as we all began to see an acceptable percentage of cases improve. The work gradually started to assume a twinge of monotony as, day after day, the cases arrived one after another as though on a factory conveyor belt. The routine of one hour per appointment began to spill over into my social life where I was increasingly forced to resist an unfortunate tendency to automatically terminate any social encounter lasting more than one hour. So this is it, I lamented, in 20 years time I shall be looking at the same referral letters and doing the same things in the same places. In a moment of prisoner's desperation I calculated that I had 35,200 cases left to see before retirement.

I had the good fortune to arrive into a welcoming set-up where intra-team relationships were on the whole good. I felt as though I had joined a family as a distant (rediscovered) senior relative. It did not prove difficult to establish myself as chairman and clearly in overall charge of referrals addressed to me. To date there has not been the political hassle rife in some more urban clinics. We started regular 'workshops' defined as learning time for the team. These have become a useful forum for liaising with workers in other related disciplines.

The initial lack of feedback from colleagues did make my position feel more isolated than anything I had experienced during my training. One social worker's initial reticence, it later came to light, was due to the fear of being filmed by the video equipment I had talked so enthusiastically of acquiring. Looking back, other team members may also have felt a little threatened and potentially de-skilled by my initial anxious mania to introduce a swarm of innovations fresh from the Capital. It has been vital to appreciate the skills already present on the team.

The biggest task of the first year has been to develop relationships with referrers and the vast network of other agencies involved with children and families. At times the number of superficial relationships I have been obliged to maintain has seemed overwhelming. Families, other professionals, and myself have shared confusion about the roles within the network. The task of working out these interrelationships and roles has seemed formidable, but attempts to apply 'network therapy' to cases of diagnosis 'network confusion' has led to interesting revelations, such as the number of professionals who perceive themselves as Super-Parent or even God.

Ignorance of what modern child psychiatry has to offer was still in abundance. Although there was no shortage of referrals, the work of engaging many families would have been easier had they been better prepared by the referrer for our way of working. For instance, why we should want to see the whole family was often not understood by referrers. Many referrals were inappropriate, e.g. homeless children. I tried to find every opportunity to talk to relevant professional groups. On one occasion I gave a talk to GPs in the local postgraduate centre on modern treatment methods in child psychiatry. I had prepared the talk to be down to earth and eclectic, looking carefully (and critically) at the contribution of each treatment. I re-donned the pin-striped suit, hoping to come across as straight, safe and competent. However, many questions revealed an ignorance of child psychiatry even greater than I had planned for. Family therapy was received as either a marvellous new panacea or with extreme suspicion. I left feeling like a revolutionary. From other talks I have emerged feeling like Billy Graham, Einstein (having been too intellectual), and Spike Milligan (too manic and over-inclusive). But an increase in appropriate referrals, decrease in failures to attend, plus being addressed by my Christian name on much fuller referral

letters hopefully points to some progress.

It was a visit to hold a family group around a sick member in a small private nursing home, a converted large Victorian villa peacefully secluded amongst gardens and trees, that hit home to me the shabby, overcrowded conditions in the clinics that we had almost become immune to. The nursing home's silent wine-coloured carpets, panelled walls, and spacious well-decorated rooms all imposed an air of high quality on even the most menial of work going on there. In my training years, while my bosses had ranted about the politics of obtaining premises or other resources, in my professional idealism I had day-dreamed about spectacular psychotherapeutic interventions (or holidays) and wondered why they were going on so. But now every brick that we obtain towards a proposed new child psychiatry out-patient unit is, for us, a major talking point to the ennuie of those not involved.

It is far more difficult to pursue a Jekyll (work) and Hyde (not at work) existence away from the Capital. Loss of London's anonymity was acutely mourned one day whilst I was walking down the street carrying a teddy bear. This large, furry object was en route to play the part of an infant in a family therapy demonstration role play we had organized for the new local branch of the Association for Family Therapy. I became uncomfortably aware that one of the families I had in treatment was watching me. My attempts to hide the enormous animal made me even more conspicuous until my registrar came to the rescue.

A year ago I would never have thought I would ever find the time to write this article. Perhaps now that I have is a measure of becoming 'established' so that I now feel I control work a greater percentage of the time than the reverse. The clinic teams are becoming more relaxed, confident, and highly supportive. Certainly structural family therapy lends itself well to many of our referrals, but it is sometimes necessary to point out it is not a panacea to over-enthusiastic team members. My speed of working has, out of necessity, greatly increased, but, when the referrals come in torrents, I am still frustrated at not being able to be as thorough as I would like. This, together with feelings of professional isolation, fatigue and waves of monotony at dealing with yet more products of broken marriages, has periodically led me to seek 'escape routes' in the overseas appointments column of the *BMJ*. But just as fantasies of treating one family a day on a beach on a tropical island begin to

engulf the reality of my staleness, a conference seems to pop up to provide professional rejuvenation largely through sharing with peers. Variety has also increased through taking on more training functions, development of paediatric liaison work, and instigating therapy groups for children. To date, I have not missed having an in-patient unit.

Looking back, how do I think my training has suited me for this job? I am thankful for an eclectic training that has balanced academic child psychiatry with training in therapy. Straight knowledge—including child development—is crucial in giving a balanced, objective opinion. (I remember a boss struggling to get this across to me at a time when I was enthusing about the latest and greatest psychotherapy techniques and thought reading the classical literature a drag.) However, in large part one's reputation depends on achieving results and here my training in psychotherapy—particularly family therapy—has proven invaluable. In my case I have not felt individual analysis to be necessary. Regarding the deficits, more training in how to deal with networks, and a clearer understanding of the functions of all the other professionals dealing with children would have been desirable. This may have been achieved through attachments to other professionals, particularly to an educational psychologist and to a local authority social worker.

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