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Specific counselling needs of psychiatrists

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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.

Aggressive patients are not peculiar to psychiatry; doctors in accident and emergency departments may be more exposed to violent patients. However, the systematised threatening from some paranoid patients can be worrying and the amount of aggression towards trainees by patients is another subject both senior and junior psychiatrists are often reluctant to discuss.

(3) *Personal issues*

The difficulties involved in working in teams with persistently questioning and critical non-medical colleagues is one frequently mentioned by trainees. This occurs much less often in other specialties.

Regrettably senior medical colleagues may also be seen as critical and over-demanding rather than supportive and constructive by some trainees. Although this is hardly peculiar to psychiatry, it is resented in our specialty perhaps because psychiatrists are expected to be more patient and understanding than other specialists.

Psychotherapeutic methods may give rise to self-doubt and questioning in the trainee. Macaskill (1988) has described this in doctors undergoing personal analysis. Many junior doctors prevent potential discomfort by avoiding psychotherapy experience and this is sometimes condoned by clinical tutors and even psychotherapists themselves. My own view is that no-one can be regarded as a fully-trained psychiatrist without well-supervised psychotherapy training and experience and that dealing with the feelings and stresses produced by this is an essential part of the unique learning process involved in becoming a psychiatrist.

I have not dealt with the important but separate issue of who should counsel. *Achieving a Balance: Plan for Action* does, of course, suggest a sequence of consultant, clinical tutor (and/or specialty or College tutor) and post-graduate dean. This reflects current practice in most areas although district clinical tutors report little contact with trainee psychiatrists and post-graduate deans are usually directly involved with counselling only a minority of doctors.

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Career counselling of overseas doctors

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The days have gone when medical graduates could safely assume a relatively trouble-free progression in the career of their choice. The shortage of medical graduates and expansion of the National Health Service in the sixties and seventies created a scenario which not only allowed UK graduates considerable choice and ready promotion but sucked in a large number of doctors from third world countries who arrived here with the aim of obtaining training and medical and surgical diplomas much prized in their countries of origin. The absence of training in psychiatry at undergraduate level as well as low prestige and limited opportunities for private practice in psychiatry in the country of origin meant that the majority of third world doctors arrived in the UK to train in other branches of medicine. Many, however, found it difficult to pursue their original objective and gravitated towards other branches of medicine including psychiatry. In other words, market forces were already operating before the term came into common usage, bringing in a supply of labour to an expanding market: having arrived, further stratification then took place.

By the early seventies concern began to be expressed about the competence of many such doctors, and the Merrison Committee in 1975 made several recommendations requiring overseas doctors to take a test of professional competence at the level of Senior House Officer as well as a test of formal and colloquial English (PLAB). In spite of this screening procedure to ascertain minimum levels of competence of overseas doctors from third world countries, doubts still lingered in the minds of many regarding the overall competence of these immigrant doctors. Overseas doctors therefore have been perceived as being "less than full" physicians – a concept which has widespread and serious implications. The professional and cultural competence of these doctors is a critical gate-way to other forms of learning. The doctor who is regarded as less competent in these areas may, in the end, become less competent as he will receive a lower quality of education.

There is an ambivalence about the presence of overseas doctors in the National Health Service and our historical dependence on them even though they have often fulfilled a residual role in taking up posts which were not sought by indigenous graduates. Many overseas doctors who are working in the NHS will be facing the dilemma of whether or not to return to their country of origin. The decision not to return may be influenced by political factors or financial and professional considerations. Having practised