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Part-time higher training in child and adolescent psychiatry

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The rise in the proportion of female medical graduates has led to an examination of the alternatives to full-time continuous postgraduate training. Part-time training has become more common, particularly in psychiatry and non-acute specialties. The means of establishing this type of training have been described in detail (Royal College of Psychiatrists, 1987) and the training requirements are discussed in the JCHPT Handbook. However, when part-time training is written about it is presented as a daunting process, fraught with concerns about a less than optimum training and practical difficulties. The survey by Ann Gath (1988) of supernumerary senior registrars in child and adolescent psychiatry detailed problems such as prejudice, a sense of exploitation, and lack of support and advice. These issues are clearly of great importance to those considering this option but there is also a more positive and optimistic view of part-time training which seems of particular relevance to child psychiatry. At the time of writing I am nearing the end of my higher training on the PM 79(3) scheme and am in a position to describe some of these more positive aspects.

Support

My post is part of a large and well-organised rotation which has a history of accommodating part-time trainees who have successfully moved on to consultant posts (both full and part-time). I work seven sessions; five of which are clinical, one research and one participating in an academic programme. The co-ordinator of the rotation and the Regional Post Graduate Dean are active in their support for part-time training and this ensured that the process of obtaining educational and manpower approval was facilitated. There is also considerable peer support from the other trainees who form a cohesive group and meet regularly. This cohesion has limited the potential for marginalisation of the part-time trainees.

A wide range of opportunities

Within my region there are many clinical settings which are not used regularly in the senior registrar rotation and consequently no shortage of consultants able to provide support and clinical supervision. The creation of a suitable educational programme was relatively straightforward and allowed much more flexibility than was possible for the full-time trainees who were committed to filling particular posts. The difficulty was in deciding between so many interesting and relevant opportunities to achieve a well-balanced and exciting mix.

The range of experiences recommended by the JCHPT is extremely wide and it is quite a challenge to meet these requirements within three to four years of full-time training. Although my training is equivalent to this, it has extended over a much longer period and I have worked in five separate placements. Thus I have gained experience in a wider variety of settings than is usually possible and there has been time for my knowledge and experiences to be consolidated.

The definition of role

One of the problems my full-time colleagues regularly struggle with is the conflict which can arise between their training needs and the service needs of the setting in which they work. As each of my placements has been within a team which usually functioned without a senior registrar, this problem has been largely avoided. I am clearly supernumerary to the team and there are few rigid expectations of particular tasks or responsibilities which I am expected to assume. As a result I have been freer to make use of opportunities both within and outside the clinical setting to meet my own training needs. For example. I have been able to negotiate to spend time working with the adult forensic psychiatrists in order to supplement my understanding of a particular aspect of my clinical work.

This freedom also creates a challenge in that I need to establish a role for myself within the team. My task has been to present myself as willing and able to learn from my colleagues but also bringing skills and experience from my past training. Joint work and participation in team case discussions facilitated this process. I have also been able bring new experience into the team – for example, previous

participation in multidisciplinary clinical audit proved of great relevance when working in a team wanting to set up such a project.

Having joined a team, it is also important to remember the time-limited nature of the placement. Any projects need to be either joint initiatives with another team member who is prepared to continue with the venture or set up with a clearly defined time span. In one placement I organised a series of seminars for the staff of a local special school to provide in-service training and staff support. I was careful to involve my colleagues in the planning stage of the project and to include them in the programme so that the liaison links did not depend on my presence. The experience of setting up this initiative was a valuable one but it was important to consider how the project could continue after I had left.

Being there only half the week

One of the areas I had expected to be problematic was that of part-time availability. I had expected that my colleagues would be irritated by this and that I would find it difficult not to take on more than could realistically be managed. My experience has been that neither of these things happened. A part-time commitment to a particular setting is familiar for many multidisciplinary team members in the specialty. Part-time working is also quite common in other disciplines. As a result, there is likely to be less anxiety about a psychiatrist being available for only some sessions and less in-built prejudice about such a post.

There still remains the possibility of misunderstandings about the time available for clinical work, especially if domestic commitments mean that timetabling has to be relatively inflexible. There will always be those who find it difficult to accept that child care arrangements are as complex to reorganise as conflicting clinical responsibilities. I have found that, once established, the boundaries between work and other commitments have been well respected by my colleagues. although I have not worked on a part-time basis in an in-patient unit, where the demands for availability and continuity may be more pressing, I suspect that problems about part-time availability can be overcome.

It has become clear to me that the initial negotiations about session times and availability are crucial to avoid misunderstandings later on. In order to do this, I have been careful to find out about the team and its functioning. Attendance at the fixed commitments for the whole team (i.e. team meetings, case discussions) is a crucial part of the work and it is unlikely that this can be altered. I have learnt that it is important to understand factors such as colleagues' work patterns, the need for emergency cover, co-working arrangements, and room availability. It is also essential to be clear about my own needs. Once these constraints have been clarified, I have found it possible to negotiate workable arrangement. In doing so, it has sometimes been necessary to make a choice between two conflicting options and I have been particularly careful to avoid filling my timetable with meetings.

Too much to do and too little time

Although I have found the area of clinical commitments relatively easy to negotiate, there are areas where the time constraints do present problems. Preparation for the academic seminars, background reading, attending audit and management meetings, conferences and research can all be timetabled but often fill more time than is realistically available. This problem is not unique to part-time training and it is necessary to develop a highly organised plan to meet these demands, mirrored by a well organised structure for coping with non-work responsibilities. Creative solutions are possible if there is support and encouragement. For example, I have been able to incorporate a child psychotherapy diploma course into my training by setting aside one of my sessions for this work.

Part-time training as a child and adolescent psychiatrist is not an easy option and the difficulties described by others are real. However, it is possible to complete a comprehensive and interesting training on this basis when there is the appropriate support and encouragement. There are also advantages which are not immediately obvious such as the greater flexibility of training experience and the challenge of negotiating and establishing boundaries and a role in different settings.

References

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