Organising induction courses in psychiatry*

Ken Slatford

Induction courses can offer trainees many benefits. These include a feeling of being welcome, a sense of belonging, reduced anxiety and increased confidence about the work ahead. The benefits to services include increased morale and efficiency brought about the trainees' quick orientation to their clinical roles and the organisation of services. This article considers induction to a hospital unit, to a hospital, and to regional services.

Induction meetings and courses can offer new trainees many benefits. These include a feeling of welcome, a sense of belonging, reduced anxiety and increased confidence about the work ahead. Benefits to the service include increased morale and efficiency brought about by the trainees' quick orientation to their clinical roles and the organisation of services. Induction can be used at different levels of organisation. Here I consider induction to a hospital unit containing say one to three consultants, induction to a hospital, and induction to regional psychiatric services.

The following guidelines and suggestions are based on my experience as a senior registrar, when I organised a hospital-based induction course for the South East Scotland Regional Training Scheme in July 1990. Subsequently, as a consultant and clinical tutor in July 1992 I organised an induction hand-out and meeting for new trainees coming to a much smaller psychiatric hospital with only three consultants (Rosslynlee Hospital in Midlothian). In retrospect, and taking into account the feedback of trainees, the following principles emerged.

(a) planning an induction course takes time, involves careful consultation with relevant parties and works best when it involves junior staff currently in post and systematic feedback from inductees
(b) induction courses are popular with trainees and facilitate rapid integration into units, hospital and regional training schemes
(c) tours of hospital are very popular
(d) the timing of sessions is crucial
(e) the content of sessions must be relevant to the new trainee
(f) trainees like tutorial-style discussions involving hand-outs and videos
(g) written material should be available for future reference, be up-to-date and relevant to the new trainees' needs.

Since different levels of induction (unit, hospital, region) require different approaches and contents depending on local factors, I have not provided a rigid blueprint for these different levels but some suggestions which can be modified for local use. Thus, all the content of each level may not apply to different schemes and separate elements described in different levels may be combined in one induction course for the needs of a particular scheme. Further, if induction courses are already established in your scheme, much less planning may be required. Generally, however, induction at higher levels requires more planning, consultation and administration. At each level I will consider planning, timing and staff, and content.

General points relevant to all levels of induction

Arrangements should be made to ensure the attendance of all new trainees if possible. This requires adequate notice, mandatory attendance, and agreement among senior staff that either current staff cover the clinical work that arises during induction (if the meeting occurs before change-over), and that other (probably senior) staff cover if the induction course follows the change-over. The meetings should be free from bleeps.

With unit inductions it is sometimes appropriate to hold meetings out of hours at the hospital or at a consultant's home where the atmosphere may be more informal and friendly. The anxieties and concerns of new trainees should always be addressed by allowing questions, discussion and access to 'mature' trainees.

*This article was presented to the Psychiatric Tutors Sub-Committee and accepted by them for inclusion in the Clinical Tutors Handbook. I hope that it can act as a help and stimulus to further development of induction in psychiatry. The College has said that training in the administration of ECT and safety in psychiatric practice will be mandatory in induction courses in the future.

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Hospital unit induction

Planning

The permanent staff of a unit should produce an induction hand-out describing their service, including guidelines regarding referrals, admissions out of hours and during the day, note-keeping and letters, times of meetings, how to get advice urgently, timing of supervision sessions, rota cover for emergencies and ECT etc., reporting of sickness and absence, annual and study leave application arrangements, keys, security, and so on. This is best revised regularly with the help of current trainees.

Timing and staff

It is a good idea to meet a few days before the change-over and to involve present trainees, consultants and new trainees.

Content

There should be a welcome, introduction to present staff, orientation to unit services and the role of trainees, discussion of hand-outs, airing of current strengths, problems and philosophy of unit, reminiscence of initial anxieties and experience of 'mature' trainees, and questions from new trainees.

Hospital induction

Planning

This is likely to involve liaison with your medical director, clinical directors and local clinical tutors, and discussion of the proposed content at appropriate hospital or medical staff committees. If tutorials are to be arranged these should be co-ordinated with the local university department of psychiatry, and dovetail with the local arrangements for teaching psychiatry to general practitioner vocation trainees. Your hospital handbook should be revised and updated in time for the induction. Its content should be subject to editorial revision by junior and senior staff. The best format is pocket-sized (Gale *et al*, 1992). Other written material should be prepared, such as letters of welcome with details of times and venues, timetable, hand-outs, and latest hospital drug formulary.

Timing and staff

This may require two or even three sessions within the first week, with the first session on the afternoon of the first day, allowing orientation to individual units in the morning. The number of sessions will depend on the size and complexity of the hospital. Staff involved should include a clinical tutor, previous junior staff, a senior registrar and the VIPs of the hospital, e.g. medical director, clinical directors, senior social worker/mental health officer, and a management representative.

Content

If psychiatric trainees are expected to deal with emergencies, high priority should be given to tutorials on management of psychiatric emergencies, including assessment of suicide risk, using the Mental Health Act, the prevention and assessment of violence and aggression, arrangements for personal security, and the practical details of urgent clinical support and supervision.

A tour of the hospital in small groups led by a junior doctor with time for a question and answer session should be a high priority. Written material is best used to outline services and systems, rota arrangements and systems of information processing, infection control and fire drill.

Introductions to the following clinical staff should be considered: medical or clinical directors, nursing director, head mental health officer, nurse involved with emergencies, and pharmacist; and to the following non-clinical staff: medical personnel officer, unit general manager, fire officer, medical records officer, information officer, and head telephonist. These might be combined with a brief message about their role, how to use them well, and questions.

Regional induction

Planning

This is a more ambitious concept and requires careful thought if it is to be successful. However, if new psychiatric trainees are expected to take part in a widely dispersed rotational scheme, consideration should be given to providing a regional induction course which orientates trainees to the geography, facilities and style of the various hospitals involved. This can be linked with regional arrangements for teaching and include at each site: a tour of the hospital by local junior staff; a 'high priority' seminar given by (depending on the site) a university lecturer, local consultant, or clinical tutor. Liaison with your local university, the approval of the regional tutors committee and involvement of clinical tutors at each site is necessary. Maps and timetables need to be set out well in advance.

Timing

This might take place on an afternoon each week at a different location for the first three to six weeks in August/September depending on the

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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'.

Reference

GALE, R., JACKSON, G. & NICHOLLS, M. (1992) How to run an induction meeting for house officers, *British Medical Journal*, **304**, 1619–1620.

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Psychodynamic supervision for junior hospital doctors

Eileen McGinley and Josephine O'Reilly

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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