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Consultant learning groups in psychiatry

Report on a pilot study

There is growing emphasis on the importance of continuing professional development (CPD) for consultant psychiatrists and an increasing recognition of the need for peer support. In this context the Royal College of Psychiatrists has been developing policy around CPD; a policy document has been issued by The College Council (Royal College of Psychiatrists, 1994) and there are regular updates on this topic on the website (www.rcpsych.ac.uk). All consultants are to be expected to take part in CPD and currently the annual requirement is for 20 hours of 'external' CPD and 30 hours of 'internal' CPD. 'External' refers to didactic or workshop events that involve input from outside a clinician's locality; 'internal' refers to local activities, case conferences, journal clubs, etc. CPD follows a 5-year rolling cycle, supported by the journal *Advances in Psychiatric Treatment*, a recommended 2 hours per week personal study and the development of personal development plans. From the outset there appear to have been issues in engaging consultants in CPD (Morgan, 1998). The problems of establishing CPD extend beyond consultants 'finding the time'.

For general adult consultants, the trend in recent years has been to develop sectorised community mental health services, with the effect that consultants in our health care system are now unlikely to see each other. In other words, they work 'out on the patch', at the expense of the putative informal but rich encounters with colleagues on the hospital site. Added to this is the great shortage of consultant staff and the heavy structuring of much of mental health care. CPD is just one more thing to deal with.

Nevertheless, there are educational meetings organised for consultants. This is a superficially convenient mode of attending to learning needs, as well as providing an opportunity to meet colleagues. However, such events commonly consist of speaker-based meetings, rather than interactive ones. Breaks between sessions offer the chance of only brief and transitory exchange with colleagues. Although such events are a vital part of the learning culture for consultants they cannot substantially engage consultants, either as a significant learning process or as a supportive collaborative network.

In this context, an alternative model for continuing development is the 'action learning set'. Learning sets have been developed in the business world as a response to the need for professional development of managers (Pedlar, 1996; Revans, 1998; Weinstein, 1998). In spirit they are pragmatic, in that the focus is on particular problems that drive a process of further learning for members of the set. Typically, group members bring real issues and problems from work, which are considered in the group. Potential solutions are formulated and members update the group on progress in the light of suggestions made. In addition, there is an important dimension of support from the group. Learning sets can be across institutional boundaries, often drawing members from several organisations. This paper reports the experience of piloting such a learning set for consultant psychiatrists in the North West Region.

Method

A 'Consultant Learning Group' was convened at an accessible venue in the South Manchester area that was close to the orbital M60 motorway and an intersecting trunk road. There was good access to parking. After canvassing views, an early evening slot was agreed and general adult and old age consultants in the seven adjacent districts were invited. Meetings were scheduled every 2 months and lasted 2 hours. CPD approval was obtained for six pilot sessions.

It was intended that the meetings should be congenial, and that the 'usual' rules of safe group working would apply, including confidentiality, courtesy, respect for other participants and a willingness to contribute. A convenor was identified (M.S.) to organise and run the meetings. For each meeting, one of the participants would informally present an issue from his or her clinical work. This could be a complex case, a management issue, an ethical issue or any other topic thought to be pertinent.

Following the presentation of new material and any necessary clarification, the themes and issues raised by the presentation would be collated, highlighting the

points of learning or controversy. Actions would then be agreed, for example, for a different clinical approach to be tried or for a member of the group to be delegated the task of searching for relevant literature. Meanwhile, the convenor would identify recurrent themes that would lend themselves to topic proposals for more formal seminars under the auspices of the local university or medical society. In the first instance, this group was formed under the auspices of the Manchester Medical Society. Progress on a case or issue, or the effects of enacting suggestions made by the group, is fed back in the first half of the subsequent meeting, along with sharing of any discovered literature.

Results

Five of the six planned meetings took place, the sixth failing to happen for organisational reasons. Of the 50 or so consultants originally contacted, seven people from three departments intended to attend the series and attendance ranged from four to six. An early evening, midweek slot had been thought to be possible, but there was great difficulty in finding a regular time that suited everyone.

Another 23 of those contacted wrote back expressing a significant interest in attending such a group, but said that an 'out-of-hours' slot was not convenient.

Examples of issues presented included a dilemma over a patient who had presented to casualty with a potentially lethal overdose, but who could not be determined to be mentally ill and who refused medical treatment. Discussion focused on the role of the psychiatrist, the Mental Health Act and recent articles on the subject. Subsequently, a procedure was enacted to assess competence, involving the psychiatrist, the casualty consultant and a consultant physician. The case has influenced future practice for this situation in the hospital concerned.

Another case involved a prolonged depression subsequent to a pregnancy. Discussion focused on a re-evaluation of the phenomenology and the suggestion of comorbid adjustment issues that complicated the picture. This led to a shift in therapeutic approach and a diminution in some of the behavioural symptoms that were proving challenging.

In just five meetings, themes to emerge from the presentations included:

- how to prescribe and monitor progress of psychological treatments
- characteristics and management of mental health problems in health care professionals
- borderline personality disorder, chronic adjustment disorder and affective disorder
- the paranoid illnesses
- advances in thinking in psychopathology of psychosis
- current thinking on drug-induced psychosis and its management
- oestrogen patches in postnatal depression
- treatment-resistant depression regimes
- systems therapies
- asylum, long-term care and post-rehabilitation management of severe mental illness.

These topics provided a focus for group members to study the published literature and share findings. They were also passed on to the Manchester Medical Society, who are keen to find topics suitable for their series of seminars.

Four out of the seven participants completed a brief form giving feedback on the group and additional feedback was obtained informally from the others. In essence, the opportunity to meet colleagues in an informal atmosphere and to discuss cases was viewed as constructive, supportive and stimulating. There was a general wish for such meetings to carry on. The difficulty of attending meetings regularly was an issue, as was the difficulty in maintaining the momentum of discussion between meetings, as different colleagues were able to come to different meetings. For some, the 'out-of-hours' commitment turned out to be too much after all, despite the value of the meeting. Having tried the learning group, some felt they could now themselves act as convenors in the future.

Discussion

A 'learning set' or 'learning group' model for CPD for consultants has been described that would complement more traditional educational approaches. Under the auspices of the Manchester Medical Society, some success was achieved in a six-session pilot of such a group, in terms of providing peer support, sharing of knowledge and experience and generating themes worthy of further exploration.

The organisational difficulties of establishing the group and maintaining momentum were significant, despite the high level of interest expressed by psychiatrists in this kind of approach. What would seem to be crucial is the ability of group members to attend regularly and contribute on a long-term basis. A further important point is that in the business world, advocates of learning sets envisage an even more intensive group process than we used: perhaps meeting for a whole day at a time. However, there seems to be no reason why 2 hours every 1–2 months would not work, provided the individual commitment was there.

For this pilot group it was felt that the convenor was essential to keeping the group on track with dates, venues and collation of emerging themes. In other respects the group was self-directing; other groups, however, might require some more formal facilitation to function.

Whatever the qualities of the individuals forming the group, it became clear that such groups would need to be supported by wider organisational strategies to initiate and sustain them. For example, in the setting of the Royal College of Psychiatrists' initiative to develop peer appraisal and personal development plans, there may be a natural process to establish consultant groups that could very well operate on learning-set

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lines. One or two sessions per year could be devoted to personal development plans, and other sessions devoted to action learning. Also, trusts may need to consider accommodating such activities into more 'regular hours', and groups of trusts may need to collaborate to establish protected time to enable larger numbers of consultants to participate. In some areas a pattern of clinical services that avoids clinics and ward rounds on a particular afternoon has been established.

Whatever fruitful ways there are of taking the consultant learning group idea forward further, there is a prerequisite for some more concerted planning and for the establishment of a cohort of convenors. Convenors would themselves require training and support in a learning-set paradigm, which might become the ideal platform for rolling out the project.

Acknowledgement

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