

TRAINING

Child psychiatry training for paediatric neurology trainees; a personal view

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The authors describe their experience to support the view that training in child psychiatry is an effective way for the paediatrician in training to gain an understanding of that specialty. It is also an efficient way to acquire certain skills, which will be helpful in the future, either in hospital or community paediatrics.

child psychiatry placement may help in the acquisition of these listening skills.

A PAEDIATRIC NEUROLOGY TRAINEE'S EXPERIENCE IN CHILD PSYCHIATRY (SM)

I did a three month placement in child psychiatry in my second year of paediatric neurology training. The child psychiatry team was a multi-disciplinary team, which had a consultant child and adolescent psychiatrist (with special interest in ADHD), a senior house officer, two senior community mental health nurses, a psychologist, family therapists, and an art therapist. The induction course, supervision by the consultant and "sitting in for assessments" with other team members was very helpful in gaining skills such as how to engage a family, how to help the family tell a story, and other skills which experienced practitioners take for granted. There were opportunities for difficult cases to be discussed with other team members in the weekly team meetings. I did first hand assessments of children referred for possible ADHD under consultant supervision. I also had the opportunity to see some children who were followed up by the child and family therapy team for various mental health problems, following an acute or a chronic physical illness. I participated in the academic programme which involved a weekly case presentation or journal club and a monthly training day, where all the child psychiatry teams of the region attended with interesting cases and diagnostic dilemmas.

My presence proved very helpful to the child and family therapy team and beneficial to children and their families, especially in managing a co-morbid physical illness. It was a very helpful learning experience for both the psychiatry team and me. It was an excellent training opportunity for me to understand the working patterns in a child psychiatry setting and gain some skills in mental health assessment in children.

THE CHILD AND ADOLESCENT PSYCHIATRIST'S EXPERIENCE OF A PAEDIATRICIAN ON THE TEAM (NC)

As a small community sector team, our experience of paediatricians was limited to part-time placements of community paediatrics trainees for two sessions a week over a maximum period of three months. These placements were felt to be too short, unsatisfactory, and limited. Finally we had someone placed with us for a more significant amount of time! We felt we could contribute more meaningfully to the trainee's experience of child mental health. The experience

Kenneth Calman's proposals (Department of Health, 1993) to restructure the training of middle grade staff were introduced to "produce a shorter, more structured and organised training pathway so that independent clinical competence as a consultant can be achieved much earlier than in the past in many disciplines".¹ Their goal was to provide the health service with doctors of a consistently high quality. In paediatric neurology, the Royal College of Paediatrics and Child Health and the British Paediatric Neurology Association (BPNA) guidelines recommend that this sub-speciality's training should involve, in addition to core training in paediatrics, a minimum of three and half years of training as a specialist registrar (two years in clinical paediatric neurology, six months in adult neurology, one year in neurodisability, with three months of child psychiatry).^{2,3} Currently in the UK, child psychiatry training for a paediatric neurology trainee is achieved either by doing one day per week for a year or by doing a three month slot.

WHY IS CHILD PSYCHIATRY TRAINING ESSENTIAL FOR A PAEDIATRIC NEUROLOGIST?

As paediatric neurologists, we are expected to be competent in diagnosing and managing acute and chronic neurological disorders in children. In addition, a fully trained paediatric neurologist needs to acquire skills in assessing and treating primary developmental and behavioural disorders, and in preventing and managing secondary emotional difficulties, which can arise because of major physical illness. In clinical practice, we see some children who present with neurological disorders with depression, autism, psychosis, and attention deficit hyperactivity disorder (ADHD) as co-morbid features. The psychologically minded paediatric neurologist needs to understand these symptoms and the child within the context of his family. Such an understanding may enable the paediatric neurologist to treat the child himself or alternatively prepare child and family for a psychiatric referral, if appropriate. A

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proved to be an enriching one for both parties. From the team's perspective, the trainee's continuous presence for three months allowed him to be integrated as a team member. Mutual understanding led to a natural "rapprochement" and mutual respect. We came to realise how complementary each other's skills were, and the satisfaction of the families we were seeing together confirmed our beliefs. A paediatrician's placement allowed us to offer a holistic child oriented approach.

RECOMMENDATIONS

Based on our experience, a child psychiatry placement should be for a minimum of three continuous months rather than one day a week for a year or equivalent as currently recommended by the BPNA.³ This would allow the trainee to be meaningfully involved in extensive multidisciplinary or multiagency assessments of complex cases, be involved with families needing frequent follow ups, become involved in team discussions and dynamics, and became part of the "life" of a team, albeit for only three months. It will also help the trainee understand the role of non-medical professionals (family therapists, art therapists, psychologists, etc) in child mental health. This experience is not possible to achieve on a session or two a week as the exposure to child psychiatric disorders is then infrequent and too narrow in focus.

It would be desirable for the trainee to be exempt from daytime paediatric service demands (such as outpatient clinics, ward rounds, etc). This would ensure more

comprehensive training experience and more continuity in care. This does have service implications for the paediatric neurology team for those three months. We appreciate that it might not be possible for the trainee to be exempt from paediatric on-call duties. However, the problem with covering paediatric outpatient clinics can be overcome by discussing the placement with supervising consultants, regional advisor, and the programme director well in advance.

Although we focus in this article on the experiences of a paediatric neurology trainee, we feel that even a general paediatric registrar planning a career in community paediatrics or in hospital paediatrics, should have a three to six month placement in child psychiatry. The skills gained during this period can be effectively used in future, either in hospital or community paediatrics. We are in the process of actively pursuing this avenue locally.

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ARCHIVIST

Endobronchial biopsy

A report in *Archives* in 2001 (84:423–6) gave details of 73 children (38 with severe asthma) who had undergone bronchoscopy, bronchoalveolar lavage, and endobronchial biopsy under general anaesthesia at two specialist centres. It was concluded that the procedures were safe and acceptable to parents. Two more papers on endobronchial biopsy appeared in a recent issue of *Thorax*. In Springfield, Massachusetts (PS Salva and colleagues. *Thorax* 2003;58:1058–60) 170 children aged 2.5–16 years underwent bronchoscopy, bronchoalveolar lavage, and endobronchial biopsy using a flexible bronchoscope with a laryngeal mask airway and general anaesthesia. At least three biopsies were taken at each procedure. Children under 4 years were given a single intravenous dose of antibiotic after the procedure. The most common reasons for bronchoscopy were chronic cough (98 patients), asthma (39), and recurrent pneumonia (15). The children tolerated the procedure well. None needed topical adrenaline to control bleeding and none developed pneumothorax, haemoptysis, pneumonia, or significant fever. One patient had an episode of prolonged oxygen desaturation that resolved with positive pressure ventilation. Attempted biopsies on three children aged 6–30 months produced inadequate specimens.

The report from London (S Saglani and colleagues. *Thorax* 2003;58:1053–57) concerns 33 children aged under 5 years (mean 31 months, range 4 to 59 months) who underwent bronchoscopy, bronchoalveolar lavage, and biopsy and 33 controls who had bronchoscopy, and usually lavage, without biopsy. Bronchoscopy was done with a flexible bronchoscope under general anaesthesia. The reasons for bronchoscopy were similar to those in the American series. Adequate biopsies were obtained from 30 children. Complications during the procedure included cough, oxygen desaturation, and laryngospasm. After the procedure fever was the most common complication, occurring in 16 of the 66 children. Intraprocedural complications occurred in six of 33 children with biopsy and 8 of 33 without biopsy. Postprocedural complications occurred in 13 and seven respectively. Neither intra- nor postprocedural complications were significantly more common in the biopsied group. Clinical management was influenced by the biopsy findings in 16 of 27 children with cough or recurrent lower respiratory tract infection as the indication for biopsy.

Endobronchial biopsy appears to be fairly safe in young children, adding little to the risk of bronchoscopy and bronchoalveolar lavage. The London workers envisage it as a research tool for investigating young children with asthma. Such research should be confined to experienced specialist centres, and presumably to children with severe asthma in whom the investigation might be considered on purely clinical grounds.