The Future of the Consultant in Psychiatry

A Report to the College

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In October 1982 Council discussed a paper by me with the above title in which I posed a number of questions. The document was then widely debated within the College, and on the basis of responses received I presented a report to Council in October 1983. Council endorsed a number of recommendations and these are now embodied in this paper.

Generalists, specialists and special interests

It is envisaged that Child and Adolescent Psychiatry will continue to be practised by specialists devoting their time exclusively or mainly to this work. In other specialty fields, such as Mental Handicap, Forensic Psychiatry, Psychotherapy, Psychiatry of Old Age, Alcoholism and Drug Dependence, and Rehabilitation, a limited number of 'pure' specialists should still be generated, probably to work chiefly in academic centres and to provide leadership in teaching and research.

The bulk of specialist work will in future be shouldered by general psychiatrists, either on the basis of taking a special responsibility or adopting a special interest. 'Responsibility' would entail a contractual obligation to organize and provide a specialist service, whereas 'interest' would necessitate spending a few sessions a week in the specialty. In the course of his consultant career a general psychiatrist may well change his 'interest' after some years, and this should be allowed for. It is not envisaged that the days of the 'pure' general psychiatrist are over and a number of such posts could still be maintained.

Bids for new consultant posts and redesigning of vacated posts are strongly influenced by Cogwheel Divisions or similar medical advisory bodies. Individual job descriptions are scrutinized by the College Regional Adviser. Council recommended that the preferred balance and pattern of jobs sketched out above should be made widely known to College members generally since they may find themselves taking part from time to time in manpower decisions.

Consultants without trainees

Implementation of the Short recommendations would increase the ratio of consultants to trainees (though probably not so dramatically in psychiatry as in other medical disciplines). The gradual elevation of standards of training by the Approval Exercise may lead to a condensation of training centres leaving certain hospitals without trainees. Council acknowledged the likelihood of this trend and noted the possible adverse effects upon quality of service, morale, emergency cover and consultant workload. The feasibility and acceptability of manning a clinical service with consultants assisted solely by associate specialists, clinical assistants and hospital practitioners was largely conjectural.

Council took the view that the College should prepare for an increase in the proportion of hospitals and units working without trainees. It recommended: (a) that a study should be made of those establishments already in this case, with particular reference to patterns of staffing and views of consultants in situ; (b) that the Dean should be invited to raise with the Central Approval Panel and the Court of Electors the possibility of moving to the approval of posts rather than hospitals—this could preserve a trainee presence in more hospitals; and (c) that the question of raising the standard of non-trainee supporting staff should be explored, including further consideration of the shelved proposal to develop a new College Diploma in Clinical Psychiatry.

Relationship to general practitioners

A surprisingly large number of psychiatrists have begun to work closely with general practitioners in the primary care setting. The patterns of collaboration vary. The Royal College of General Practitioners is interested in these developments and would welcome a joint endeavour to promote evaluation and to clarify policy. This interest was cordially reciprocated by Council.

Council endorsed the view expressed by many members that the general practitioner was a crucial link in the referral process. Self-referrals should not be encouraged or even countenanced except in emergency situations. Even then the GP should be brought into the picture as soon as practicable. It was appreciated that referrals from sources other than GPs are liable to occur, particularly in child and adolescent psychiatry, mental handicap and in forensic work.

Relationship to non-medical disciplines

The College's policy in relation to the multidisciplinary team and medical responsibility had been stated in the Memorandum endorsed by Council in 1977, 'The Responsibilities of the Consultant in Psychiatry within the NHS' (*Bulletin*, September 1977, and reprinted in this issue).

There was a striking consensus within the College on the desirability of maintaining the 1977 statement and this was also endorsed by Council. The multidisciplinary approach is to be regarded as a valuable instrument in modern psychiatric practice. It is likely to work smoothly when due regard is paid to the skills and valid responsibilities of all the professionals concerned. Problems may arise, however, especially in forensic and mental handicap practice, in the

move to community psychiatry and in the case of NHS consultants operating in other administrative contexts, e.g. child guidance clinics.

Council recommended that this whole area should be kept very much under surveillance, perhaps through the Public Policy Committee. Members in difficulty should be offered guidance on request.

Continuing education

The Consultant is likely to take a more critical view of his up-to-date competence under the stimulus of medical audit, the Health Advisory Service and the Mental Health Act Commission. The need is very clearly felt and articulated throughout the College for continuing education.

Concern has been expressed for consultants working in isolated situations who might be hard pressed clinically, perhaps working without trainees, the very people who need an educational stimulus. Pressure for adequate staffing levels in this context is imperative.

There was little support for mandatory requirements for attendance at educational events; for taking up study leave and sabbatical leave. Medical audit, however, was seen as an important educational vehicle—regular peer review, e.g. at admission and discharge conferences; meetings to assess episodes of suicide or violence, perhaps under the auspices of Cogwheel Divisions.

Council endorsed the following recommendations:

(a) The College should take a major initiative in the field of continuing education.

(b) The Education and Programmes and Meetings Committees should review the issue and make proposals. The College, for example, might arrange regular meetings designed for consultants to include reviews of recent developments in psychiatry; teaching methodology and sessions devoted to special interests. The surroundings should be pleasant and conducive to relaxed, social contacts.

(c) Chairmen of Divisions and Sections should be sensitized to the need for initiative in continuing education, e.g. in setting up local programmes, perhaps in concert with academic departments.

The Responsibilities of Consultants in Psychiatry within the National Health Service

This document, originally published in the *Bulletin,* September 1977, is now reprinted on the instructions of Council. The reasons for this decision are incorporated in the fourth section of the paper by me, 'The Future of the Consultant in Psychiatry', which appears in this issue.

Council has reaffirmed its support for the value of multidisciplinary team working in clinical practice, while remaining conscious of the difficulties that may arise in particular specialties and in certain administrative contexts.

Council has been greatly exercised by problems of confidentiality in the team setting, especially where information may pass to agencies outside Health Services jurisdiction. Attempts are being made at various levels to resolve these issues.

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The following report has been adopted as College policy by Council. The need for this arose from a number of sources: statements contained within the published Reports of Committees of Inquiry and requests from other professional bodies and from members of the College and others. At the same time it was necessary to outline the College's policy in regard to the multidisciplinary team concept and to relate consultant responsibility within that framework.

The responsibilities of a Consultant Psychiatrist are similar to those of other consultants within the National Health Service. The few differences arise from the special circumstances within the specialty, particularly relationships with other disciplines. The ability of Consultants to accept medical responsibility rests on their training, qualifications and statutory responsibility. Medical qualifications carry professional, ethical and legal responsibilities. These responsibilities are exercised towards and given by the public; are aimed at the cure or alleviation of human suffering; are independent of remuneration; and follow the medical practitioner wherever he may be, even within his private life.

In common with all medical practitioners, the Consultant is governed and licensed to act by Parliament. The Medical Acts govern the conditions under which the public can recognize and expect a basic standard of treatment for illness. Within these Acts the governing bodies for standards are set up, and the General Medical Council supervises the standards of training in medical schools, maintains a Register of recognized practitioners, and enforces an ethical code through its disciplinary body. This body exercises an ultimate power to remove the name of the doctor from the professional Register. From a doctor's point of view, this power represents an ultimate discipline and deterrent, and the medical profession operates within this framework of governed professionalism. It is a personal matter for doctors to uphold standards within this framework. They must act within their own professional conscience arising from the confidential relationship with the patient and within the limits set by law and society. It also leads to the insistence by