Uncertainty, regulation and psychiatry

Invited commentary on … uncertainty in a world of regulation

Fiona Subotsky

Abstract There is much uncertainty in psychiatry, particularly because of conflicting values. Awareness and tolerance of ambiguity are necessary for a psychiatrist, but they do not obviate the need for improved regulation, both at the level of the protocol and for overseeing performance. The professional should not to be free from regulation but should be an active participant in developing and improving it.

'Medical uncertainty and medical collegiality [are] the twin pillars of medical culture' (Rosenthal, 1999). Bernard Shaw, of course, had argued that these elements ensure that 'all professions … are a conspiracy against the laity' (Shaw, 1946 reprint).

One might argue that the public have joined in this conspiracy by demanding at least the appearance of authoritative certainty; moreover, lawyers and medical employers are keen on assignable blame when things go wrong. However, there is not always a 'technically correct' answer, as Coles (2006, this issue) points out, and in complex situations where occasionally a series of mishaps coincide, leading to a bad outcome, it may be the 'system' that warrants at least as much attention as an aberrant doctor. Coles argues that professionalism requires practical wisdom as well as technical expertise, and that there is a danger that regulation may increasingly concentrate on factual knowledge and specifically definable outcomes (for instance performance indicators), to the detriment of practical wisdom.

The Chief Medical Officer, Sir Liam Donaldson, has just published his long-awaited proposals for future medical regulation in the UK (Department of Health, 2006). Bearing in mind Coles' strictures, is there a threat to psychiatric professionalism, or could its practice be enhanced by further regulation?

Psychiatry is replete with uncertainty and, compared with most medical specialties, is especially exposed to 'value conflicts' (Fulford, 2005) – in particular the possibility of removing liberty from an individual against their will because of the risk they present to others and themselves. Although this action is subject to regulatory checks and balances through the Mental Health Act 1983, it is clear that the decision-making is a key reason for the employment of a psychiatrist. However, although there is guidance there is not a protocol. The psychiatrist is expected, in this emergency, to use his or her own technical knowledge of psychiatry and the law and the 'practical wisdom' of experience and local conditions. Variations of judgement will occur and the psychiatrist will be expected to account for them. This regulation is not usually resented (except on grounds of excessive bureaucracy) if it appears to support professional ideals such as providing assessment and treatment for people with mental illnesses, in their own interests and the interests of others. Proposals to change the Mental Health Act in England and Wales have, however, conflicted with psychiatric values and been opposed (Zigmond, 2004).

Another form of regulatory intervention which is resented by psychiatrists is the system of compulsory homicide inquiries. Hindsight frequently finds errors in 'service delivery', although these may not have affected outcome (Szmukler, 2000). Otherwise psychiatrists have been expected, as other doctors, to abide by the General Medical Council's (GMC's) requirements of good medical practice, to undertake appraisal within their trusts and to pursue continuing professional development, which is monitored by the Royal College of Psychiatrists.

Donaldson argues that, in the light of the Shipman (Smith, 2004) and other inquiries, this situation is not good enough. He draws an analogy with the airline pilot, who much of the time is following set routines (protocols) and is supported in decision-making by computerised systems. In emergencies and difficulties it is the pilot who makes the 'override' decisions, based on knowledge, experience and skill. The object is clear: to get the aircraft and passengers safely to their destination. This is clearly 'professionalism' – the authority and expertise to deviate from protocol when necessary. However, pilots are highly regulated, with regular testing of their skill and capacity.

Psychiatric practice is much less standardised and rarely has computerised support systems and aids to decision-making. Policies, however, proliferate in

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mental health services, and sometimes appear to be methods for devolving risk that lack clarity on how they might be put into practice. Coles argues that protocols and regulation inhibit professionalism. I would argue that the medical professional should follow protocols (evidence-based as far as possible), but senior professionals should be able to develop, review and modify the protocols and, when appropriate, override them with the expectation of having to justify this. If the performance of such protocols can be safely devolved to other, non-medical, professionals then there is an economic argument that this should be done.

Donaldson's report on regulation refers to the Kerr/Haslam cases – two consultant psychiatrists who were the subject of an inquiry following complaints by patients of sexualised behaviour over many years (Department of Health, 2005). Could better governance and regulation have prevented this? Arguably, yes. 'Unusual treatments' such as Kirlian therapy, electrosleep, carbon dioxide therapy and massage were Haslam's specialty. Whether or not there was some evidence base for such treatments, they provided a risk situation. Policies for chaperonage, monitoring of all treatments and 360-degree appraisals might have prevented this situation or picked it up earlier. We cannot argue that this is exceptional when the most frequent reason for GMC findings of serious misconduct by psychiatrists is sexual impropriety (Subotsky, 2006). There are also concerns about the relatively high number of psychiatrists who are referred to the National Clinical Advisory Service, although the reasons for this are not yet clear (National Clinical Advisory Service, 2006). Donaldson recommends the implementation of the GMC's proposals for revalidation for 'licensing', but also a regular 're-certification' process to be run by the medical Royal Colleges. Here is an opportunity for engagement to set our own appropriate standards.

What is needed is not necessarily more but better regulation that psychiatrists can see as enhancing their work, which in itself tolerates but seeks to reduce uncertainty.

Declaration of interest

None.

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