Correspondence

Consultant responsibility

DEAR SIRS

I should like, through your columns, to draw upon the experience and opinion of College members in respect of an aspect of consultant responsibility which appears at least as problematical as participation in a multidisciplinary team.

It appears now to be common practice in psychiatric hospitals for a single nominated consultant to be associated with the ward or wards designated for disturbed or especially difficult patients. This arrangement is likely to apply at least at the level of 'clinical administration' of the ward (i.e. determining policies and monitoring their implementation); it will perhaps also extend to the clinical management of the individual patients throughout the period of their stay on the ward. There are sound reasons in favour of such a scheme—it facilitates the establishment of a unified ward team who can evolve and pursue a consistent therapeutic philosophy for all patients; ward activities are not interrupted by regular (or irregular) visits by numerous consultants; junior doctors appointed to the ward for training experience are responsible to a single consultant. For individual patients there will, of course, be some discontinuity of medical supervision in addition to the other changes inherent in the transfer to the 'disturbed' environment; it is likely, however, that consultants will have satisfied themselves that proper consultation on treatment plans takes place at the time of admission and at appropriate stages throughout the patients' stay, so that the management in the ward is consistent with the long-term treatment plan.

In practice, arrangements of this sort can work very well. Problems arise, however, when the question of consultant responsibility is addressed, particularly in relation to detained patients for whom the concept of a Responsible Medical Officer (RMO) applies. To what extent can the original consultant be held responsible while a colleague is making day-to-day decisions (such as leave arrangements or modifying medication regimes)? I understand that in some units the patient is formally re-allocated to the ward consultant for the duration of the stay, even if this is only for a day or two; is this practice not inconsistent with the spirit of the Act (which emphasises a comprehensive and continuous treatment plan) by distancing the patient even further from the clinical influence of the Consultant who will be responsible for providing care and treatment on a long term basis?

The essence of the dilemma appears to be this: can a consultant, who undertakes full responsibility for the clinical care of his patient and is professionally accountable to the Courts and the GMC, agree to share his responsibility with a colleague who has attained equal status? And if not, how can the best interests of patients and ward staff be served, in accordance also with the recommendations of the supervising authorities (ENB and JCHPT) who will not give educational approval to units where several consultants manage their patients independently?

I would be interested to hear the views of the College and of your readers on this difficult issue.

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Listening to the relatives!

DEAR SIRS

Interviews with patients' relatives are part of our everyday work and are important in terms of diagnosis, treatment, discharge and prevention of relapse. Yet in these days of audit, when most of our items of work are counted and compared to an ideal average, interviews, which are time-consuming and good for consumer satisfaction, are seldom recorded. How many, with whom, where, why...? To answer these questions for an average consultant psychiatrist working in a district general hospital psychiatric unit a year's prospective study was made.

There were 730 interviews with 402 true relatives, aged over 16, of 277 patients. The relative had asked for the interview in 288 cases, the doctor in 266, and 176 were jointly arranged, e.g. repeat interviews. Twenty-five types of relative were seen. Female relatives came more frequently than male; more mothers, daughters, sisters, aunts, nieces etc. than the male counterparts. Were men less concerned, at work, or in the pub? Husbands, as relatives, did outnumber wives, but this is to be expected as there were twice as many female patients as male.

A hospital out-patients' clinic was the setting for 292 interviews, 147 interviews were held in patients' own homes and 89 relatives were seen on various wards. The longest and most intense interviews, 191, were held during a weekly 'relatives' clinic'. The remaining 11 were in diverse settings. The patient was present during 75% of the interviews. In almost half the interviews, information was gathered which was of value in reaching or confirming the diagnosis. The diagnoses were, in general terms, affective disorder 102, paranoid illness 49, neurotic illness 45, dementia 35, alcohol problem 24, others 22 (less than five of each). Surprisingly the relative sought a diagnosis in only 22% of interviews and the trend was that the more 'psychotic' the diagnosis the less the question was asked. In 83% of interviews joint management and treatment plans were discussed. These included admission, day hospital, clinic appointment, community nurse visits, medication, referral to psychologist, occupational therapist, physiotherapist, speech therapist and, surprisingly often, dietician. Trial periods of leave were arranged and evaluated. In 60% of interviews other

supporting services in the community were discussed, e.g. social service provisions (day centres, hostels, special services for the elderly, accommodation at all levels of dependence) or alcohol treatment agencies. In three quarters of the interviews relatives asked how they could help the patient or manage the problem. This led to discussions on interpersonal relationships, behaviour, preventative measures, etc. The relatives' own needs and emotions were prominent—guilt or anger when demented patients were admitted or discharged, or when the supply of alcohol to housebound patients was discussed. Other matters frequently raised were arranging and evaluating ECT and interpreting medical or surgical investigations and treatments. Legal matters discussed included injunctions, access and custody of children, court of protection and many aspects of the Mental Health Act.

Similar information was obtained from non-relatives, e.g. friends, neighbours and staff of old folks homes. These interviews are not included nor are the many other interviews with relatives held by other members of the team. Relatives seem to want guidance on management, information about ancillary services, but not diagnoses. Relatives have usually spent more time observing the patient than the doctor has, know what is 'normal' for the patient and may pick up early or subtle changes for the worse or better, before they are apparent to the doctor. These views must be listened to. The doctor should always ensure he is treating the appropriate person!

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ECT on OPD basis

DEAR SIRS

I was pleased to read Dr Anvil V. Shah's letter (*Bulletin*—September, 1986, **10**, 248) in which he discusses modified ECT given on an out-patient basis. His reason for doing it is the same as mine since 1945 when I was working at the Psychiatric Department of the Pazmany Peter University in Budapest. My feeling was that I had no right to admit patients, only because they were depressed, to a psychiatric ward and exclude them from their family support and home environment. I remember my first OPD treatment in 1945 of a 35 year-old female patient whose husband did not return from concentration camp. I thought she had been punished enough not to be locked up among more severe cases. Her sister came along with her for each treatment and looked after her until she recovered.

I also administered Pentothal for anaesthesia, as prior to 1942 the ECT was carried out without anaesthetics.

Since 1966 I have given modified ECT whenever I could count on the family's support. In 1974 I have established a day clinic, where cases of endogenous depression, schizophrenia, patients are receiving treatment, in florid cases two to three times a week, then in chronic cases as follow-up, once a week, then in two weeks.

Because the interior of the clinic looks like a pleasant art gallery and has little resemblance to the old fashioned surgeries or hospitals, patients are coming back of their own volition when they have recurrent symptoms.

May I also emphasise that one has to be sure of the right indications and be careful of complications; I am always on the premises and also this way no stigma attaches to the patients. They stay with the family and go back to work as soon as they recover from the acute state. And last, but not least, there is a cost saving for the government because no hospital bed is required for 24 hours, which is the most expensive part of most of the medical services.

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Hospital beds for psychiatric patients

DEAR SIRS

I am sure that Professor Priest's letter 'Hospital Beds for Psychiatric Patients' (*Bulletin*, November 1986, **10**, 322–323) was a well intentioned attempt to assist psychiatric planners to obtain more resources. However I was dismayed that he should attempt to provide figures for bed norms without relating them to other parts of the service. There are alternatives for the treatment of even seriously ill psychiatric patients. The need for in-patient beds will vary with the availability of these alternatives as well as with local psychiatric morbidity. By continuing to concentrate on bed norms in isolation Professor Priest encourages the tradition of a 'bed led' service. He then goes one step further and suggests that 30% of these beds should be empty! I do not think this approach is much help in the planning of a comprehensive service. It inevitably leads to the relative impoverishment of community resources which might offer more appropriate responses to the needs of patients.

D. MCGOVERN

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DEAR SIRS

Dr McGovern points out that there are alternatives to a hospital bed for the treatment of even seriously ill psychiatric patients. I accept that in theory, and in places, this is so, and most of us are following with interest experiments that offer a radical alternative to the traditional pattern of care.

However that was not the issue that my letter entitled 'Hospital Beds for Psychiatric Patients' was intended to deal with. The problem faced by many of our members, in trying to plan for mental health services, is that in their conversations with administrators the general rules are not clear. My letter was intended to throw some light on that. Because my letter was welcomed by the Regional Advisers—to whom it was sent in the first place—it was suggested that it might have a wider reading.