Viewpoint

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Poor ways of working: dilution of care and responsibility in the specialty of psychiatry

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It seems that psychiatry is gradually losing its allure for future doctors. All around, one can detect an air of pessimism from colleagues about the creeping 'socialisation' of this important field of medicine. There is no longer the breadth of interest in the subject and each sub-branch, for want of a better expression, has its followers and adherents. Proponents of one particular facet of treatment are zealous in the pursuit of their own interests. Psychotherapy is pitched against the neurobiological, rehabilitation and social psychiatry against the pharmacologists, all trying to mark out their own piece of territory, with some yearning for a place in the history books, or at the very least, an acronym. Some psychiatrists do not believe in diagnoses; others ridicule the concept of personality disorder, autistic spectrum disorder, or drug treatment; some believe psychiatric illness is the fault of governments, and there are probably a few who do not believe in psychiatry at all! 'Research' studies are cherry-picked by all sides to illustrate the ineffectiveness of 'alternative' treatments. The full picture or perspective of ill health is blurred and narrowed by a minority who believe they alone know what is right for patients, and psychiatry is 'intellectualised' by others to give it an air of authority and profundity it does not possess. Morale and training are suffering and, if this state of chaos and insanity continues, the discipline itself will implode and cease to be of interest to anyone, save the warring factions in the profession itself.

Once upon a time it was considered that a reasonably broad mixture of community and hospital services would provide benefit for patients with mental illness. Staff involved in their care, who have the rather cumbersome and oxymoronic description of being called 'mental' health professionals, would also widen their experience because of the continuity of care provided. It was hoped patients who clearly did not need to be in hospital (for example, waiting for appropriate accommodation) could be discharged. Clinical need would determine those who required further rehabilitation/treatment in hospital, and would not be swayed by pressures, often financial, to discharge. Now, with the setting up of Home Treatment and other teams the situation has ironically worsened, because there is an implicit opinion in this arrangement that hospital admission, even for the seriously ill or indeed violent patients, is the least desirable option and something to avoid at all cost, even when care in the community is not immediately available or adequate. Care provision for the elderly is a separate concern and is not under discussion here.

In the domain of general adult psychiatry those patients who are in need of care, be it medical or social, are languishing at home, desperate for help, being offered assessment after assessment by disparate teams. There are not enough care professionals to cope with the demand. Home Treatment Teams in particular, are under considerable sustained pressure and stress to ensure further reduction in beds. Rehabilitation beds are being closed. 'It is cheaper to keep patients in the community', we are told. Or, if that does not suit, the liberal stance might be, 'What does hospital admission achieve'? That's fine if the problem is not on your doorstep. Psychiatrists who oversee inpatient care are also pressurised to discharge patients as soon as possible, so the very old notion of 'incarceration' (that worn-out cliché from the antipsychiatry lobby) seems facile, to say the least. On the contrary, doctors now have the added worry of prematurely discharging partially treated ('we need the beds') as well as more vulnerable patients who cannot cope. Most patients who take up psychiatric hospital beds do not want to be in hospital in the first place as they often, rightly or wrongly, do not see themselves as ill. Many hospital beds are now occupied by 'Section patients', and conversely, many very ill patients are left to go it alone because they refuse hospital admission and do not want community team involvement, yet are not 'sectionable'. The inference seems to be, 'If not sectionable or under CPA (Care Programme Approach) it is not our concern.'

Where there are sufficient provisions for outpatient care, some of the damage may be mitigated. Overworked staff including community psychiatric nurses (CPNs), support time recovery workers (STRs) and occupational therapists (OTs) often have the thankless task and enormous responsibility of seeing patients at home, some of whom are threatening and potentially dangerous, others erratic with their outpatient clinics attendance not always through deliberate evasion but often the result of the very condition causing the problem, for example, lack of insight. Other patients do not engage either through hostility or loss of motivation induced by the underlying problem, say, drug and alcohol misuse. Chronic patients are not

ill enough to be on CPA and diagnostic 'conundrums' are left to others to sort out. With the introduction of the New Ways of Working,[1] the traditional outpatient clinics are being abolished and replaced with community clinics ('short-term' outpatients really). Ideally a community clinic should be run by CPNs as they usually understand the medical, psychiatric, psychological, and social needs of patients. In the authors' opinion the clinics should be Consultant-led because despite the tendency to classify everyone as 'clinicians' many staff feel uncomfortable with this role as it implies or infers a degree of clinical responsibility for which they are not qualified. Psychiatric nurses (especially those with a general nursing background) are ideally placed to carry out this function by virtue of their wide experience; also they are aware when to seek medical help when needed. Often they are more informed about patients than the primary physician or indeed the psychiatrist because of more frequent contact, either via liaison with the hospital wards or through home visits in their role as CPNs. Nurses and other staff (for example, social workers) are involved in patients' discharge from hospital (usually determined at pre-discharge meetings) and are therefore an essential link in the continuity of patient care before patients are eventually seen in the 'community clinics'. Requests for domiciliary visits from general practitioners (GPs) to physicians themselves have become a thing of the past, with the exception of those psychiatrists working with Home Treatment Teams and Assertive Outreach Teams. Nowadays it is not uncommon for patients to be waiting months on end (more assessments) before being deemed 'appropriate' to see a Consultant Psychiatrist.

Certainly there are patients who do not need to continue seeing a Consultant Psychiatrist for years on end and should be discharged back to the GP to reduce unnecessary costs and to avoid a dependency culture, in the same way a patient with mild arthritis does not need to see a rheumatologist or a patient with anaemia does not always need the expertise of a haematologist, to use simple analogies. However, sometimes GPs are unwilling to reciprocate or feel out of depth with 'psychiatry' that this is not always possible. The chronicity of many psychiatric disorders perhaps harnesses the belief that new treatments may emerge which only a psychiatrist, with his/her specialized knowledge, can implement and deal with. This type of scenario is seen with many other illnesses in all fields of medicine (chronic psoriasis, rheumatoid arthritis, multiple sclerosis) yet no one is suggesting that GPs solely should be left to manage these conditions. It seems the clinical risk to patient care is not thought through and this no doubt will lead to serious repercussions later. In our estimation, physical and mental illnesses are so often intertwined that their management should be equally shared by physicians and psychiatrists.[2]

Swings and Roundabouts

Such is the pressure by management (under the thumb of civil servants) and 'those in the know', reverentially referred to as 'Commissioners', that health professionals in psychiatry have to defend their clinical judgment and carry out numerous risk assessments (defensive medicine) of patients who are to be discharged from the outpatient clinic back to the GP in any event. Patients may be fortunate enough to receive a few last appointments with the Community Clinic (when they are up and running: some are at the time of writing) before they are shown the door and sent back to the GP, all to save money. Packages of care will not disguise the fact that vulnerable patients are being left to fend for themselves, just as they were in the past when the large institutions closed down without any forward planning as to how and where patients would survive. Yet 'management training' and 'mandatory courses' continue inexorably, often provided by 'expert' outside speakers, costing Trusts considerable amounts of hours lost, let alone the expense, instead of employing more nursing staff to cope with the ever-increasing workload. We are led to believe that reducing 'outpatient numbers' will lead to less pressurised work on staff, which really does not fit. All that will be happening to the extent that 'outpatients' will now be filling to the brim with CPA patients (read 'psychoses') instead of a good case-mix of patients required for general experience and training. It seems to be forgotten that there are patients who feel very unwell and are unable to cope, yet are not suffering from major psychiatric disorders.

The next scenario will be the revolving door 'GP - Access/Assessment Team - possible Consultant Psychiatrist advice and at most two follow-up appointments (if one is really ill) - Community Clinic - discharge to GP system', to replace the premature hospital discharge-readmission system which failed miserably in the past. When the patient relapses (or rather, when the illness remains static) the GP refers back into the system and the whole process begins again. In this way the Trusts receive money by reaching their targets (discharging patients) and are paid a second time when GPs 'purchase' more care. Those patients with 'minor problems' (not in their GP's estimation) will whittle away and remain unhappy. 'They can always see a counsellor' is the unspoken passive riposte. Furthermore, there will be less clinical variety for doctors and students, as their work will amount to prescribing 'powerful drugs' (we are told by the antipsychiatrists), monitoring serum lithium (and other drug) levels or checking blood results and clozapine dosages, because the Talking Therapies will be curing all and sundry. If only. We are reverting to the bad old days of pseudomedicine and pseudoscience.

Academicians and those who sit on government advisory bodies with grandiose names would have us believe there are far more effective ways to support people at home, or if they have no home, a crisis house will do. Meaningless, empty statements such as 'randomised controlled trials' (given the complexity of the issues under study) often with some reference to National Institute for Health and Clinical Excellence (NICE) guidelines, are used to support questionable findings. Despite all the 'new

ways of working' national stress levels are at their highest because of rising unemployment, unexpected redundancies, increasing debt through credit card borrowing, and suicide rates are going up. New ways of Working is not working and any 'ad hoc survey' (note we did not say 'research') will reveal the depth of disillusionment all professionals in the discipline of psychiatry are experiencing, and not just the hallowed psychiatrists. Rudderless multidisciplinary teams are not the answer: teams require management. The term 'leadership' is becoming redundant (one only has to look at successive governments) and is often merely a spur for making money out of meaningless and time-wasting leadership courses which seem to be sprouting everywhere. Among the many qualities 'leadership' embraces are a sense of humour, assertiveness, fairness, creativity, openness, integrity and dedication, all to be found in one individual; presumably! Hierarchical structures may work, contrary to the sweeping statements of some,[3] because people who are experienced in medical, academic and management matters (with perhaps a sense of humour) tend to command respect from team members. It is not enough to be an expert in cognitive behavioural therapy (CBT).

No place like home

How does one establish trust and rapport with patients when there will be less opportunity to do so because their care and progress are determined by market forces? Instead of decreasing outpatient volume or confining this aspect of care to CPA patients only, outpatient departments should cater for the mounting levels of stress in the community (poverty, debts, redundancies, threatened job losses) through increased staffing levels and training/supervision of more social workers, CPNs and occupational health workers. Where possible such staff should attend as many clinics as possible (not just CPAs) to offer a more holistic approach to patient care. If anything, policy makers, clinicians, managers, carers and user groups need to collaborate and clamour for a more integrative mental health service, not fracture the already fragile set-up. Community clinics are seen as a stepping stone to discharging from the mental health services (those who set them up don't like this analogy), which in theory is a good idea. The problem lies in the precipitous nature of transfer from outpatient to community clinics. Some very ill patients with chronic conditions are ironically not a burden to the system, in that they do not need to be seen frequently nor do they not require repeated admissions to hospital, yet if left to their own devices and discharged back to Primary Care would soon find life unmanageable as they rely on the expertise of health professionals to remain reasonably stable. Many patients have physical problems, some partly the result of the very treatments given to alleviate their underlying condition (obesity, hypertension, ECG disturbances, Type 2 diabetes and so forth), and need careful monitoring and supervision which is best provided by CPNs and other staff, in the same way a Health Visitor, Practice Nurse, or Diabetes Nurse Specialist might offer his/her expertise to a GP practice.

There will always be patients who need to be seen in the outpatient department with the emotional security and staff support this provides. We are aware that some 20% of patients miss their mental health appointments but then people miss appointments for other interviews and not always because they are unwell.[4] Some people miss appointments because they feel better. This is surely not a reason for abandoning the outpatient system, which serves the remainder of the patient population quite well. We have experienced an unprecedented expression of worry and disappointment by patients who have been told they are not ill enough to be followed up at the outpatient department. Now mental health professionals are also frustrated, because they perceive their remit is to refer back to the GP as swiftly as possible, without having thoroughly assessed a patient over a period of time. First on the target list will be those patients who have not been seen by a psychiatrist for several months ('We don't see them very often, therefore what is the point?') yet many chronically unwell patients may not want to attend outpatients, or have sufficient insight to realize they need to attend, for reasons outlined above. Will Outreach Teams in every Trust be abandoned to save money? Was it not their role in the first place to help those reluctant to receive treatment? What messages are we giving to patients other than being 'just a number, a hospital statistic''? Those who have had the 'luxury' of a hospital admission usually comprise the very psychotic, and the personality disordered, and of the latter some consider they should not be in hospital anyway. The gains that have been made over the past decade in early intervention and engagement with patients by Assertive Outreach Teams will be lost. Yet, there is a continuing demand from patients and their carers to be seen by doctors.[5]

Here is how the 'new' system works. New Ways of Working, set up some years ago 1 and imposed on us, was meant to be an innovative approach to consultants' contracts by encouraging multidisciplinary teamwork ('When did consultants ever not consult their fellow professionals'?), reviewing the continued necessity for outpatient clinics, advocating more scheduled time for carers (colleagues we have spoken to cannot ever recall not seeing relatives or carers!) and more prominent roles for all team members, encouraging further education and training. Unfortunately we have gone to the other extreme and are being bombarded by all sorts of courses to the extent that much time is lost not seeing patients. Team members may and should undertake postgraduate studies. For doctors, continued professional development is mandatory. We are the only profession that requires revalidation every five years. Nothing can substitute for the medical training doctors undergo and it is a shame that the expertise of psychiatrists is diluted and devalued by their current roles as medication gatekeepers. It is a curious state of affairs or perhaps conveniently forgotten that when Trusts or 'Health Care Reformers' talk nowadays about working in teams and 'shared responsibility', the Consultant-led team concept is dismissed. Where there are Consultants who do not feel up to the role of leading a team, or are uncomfortable

making assertive decisions and would rather take a back-seat thus avoiding the responsibility of being in charge of a team, then a Specialist Registrar nearing the end of training could fill this position. Multidisciplinary means 'several' not 'equal' disciplines of learning, ideally each discipline contributing a part to the whole. The medical member of the team is nowadays confronted with the added indignity of having his/her patients described in management-speak as customers, consumers, clients, service users, in fact any title that does not describe the ill person as a patient. It also reflects a creeping normalisation of 'political correctness' thrust upon us by the social engineers and should be resisted. We want patients to be treated with respect not as 'service users', waiting for the next bus or train. Trusts are now seen to promote a business approach to health care, thereby gaining the approval of their masters, the civil servants and politicians.[6] Lots of tick boxes and targets, with subtle threats of redundancies or talks about 'natural wastage'. Meanwhile, the College sits idly by.

Another concern is the training of future psychiatrists which is slip-shod and bureaucratic (lots of forms and assessments). There is hardly any room to accommodate medical students. Junior doctors who practice psychiatry are not receiving the continuity of supervision which existed years ago. The 'junior doctor' is less visible because of European working time directives, on-call commitments with days off in lieu, study leave, annual leave, and the inevitable sick leave. Passing the Member of the Royal College of Psychiatrists (MRCPsych) exams nowadays does not necessarily equate with clinical experience anymore. Even the nomenclature is confusing - not just to doctors and management ('CT1', 'ST1' and so forth) but also to staff, and reduces the profession to an anomalous set of categories no outsider understands, not to mention the loss of identity it creates in the individual doctor. What was wrong with Senior House Officer (SHO), Registrar, Senior Registrar, and Consultant? Unfortunately, we believe it is now too late to revert this shambles born out of the chaotic modernisation of medical careers. [7]

The future is bleak and many doctors (and indeed nurses) are becoming disenchanted by psychiatry, feeling let down by a Royal College which seems to accommodate every new social trend rather than concentrating on improving the status of a once fascinating field of medicine. Lots of wake-up calls, but no-one is getting out of bed.[8] Strange having a 'trade union' that ignores its members! Could someone inform the College that nowadays most General Adult Psychiatrists are almost reduced to measuring lithium levels, advising on clozapine doses, and attending meetings. No wonder the numbers of potential psychiatrists are falling. How would this dilution of responsibility work in a surgical unit? Would the team members decide how an operation is to be carried out because one of them is trained in resuscitation? Contrary to reports[3] consultants are not happy with the present set-up, though it is unlikely our Royal College hierarchy will do anything about it. Many psychiatrists nowadays have an extensive academic knowledge of medicine, psychology, sociology, and neuropsychiatry, and no longer want to be minor players in the game, or undermined by a system that encourages power without responsibility.

Fragmentation breeds disinterest

What is the answer? The previous system, though not perfect, worked well. This had its shortcomings too (oversized catchments areas, Consultants in charge of many wards, and so forth)7 but the continuity of care was there. Patients discharged from hospital were seen by the same team. GPs could refer directly to Consultants (as is the case in other medical specialties) and patients were then seen in the outpatient clinic. However, often the patient would attend such clinics for years because GPs were reluctant to resume care. Nowadays the training and education of GPs is exemplary and most are more than capable and indeed willing, to continue to provide support for their patients provided there is a back-up plan. The academic training of psychiatrists has never been better but their clinical skills are suspect. Therefore there needs to be an overhaul in the examination system as well. Actors are not patients. Simulated psychiatry is not the same as simulated surgery. Simulation is a technique not a technology, we are told. It is not a substitute for doctors examining real patients in real contexts. The same applies to nurses. All nurses (CPNs) could easily be trained to do ECGs, act as phlebotomists, and arrange routine tests. Many already do. Give back to nurses the skills they enjoy in other fields of medicine. For psychiatrists there are numerous courses one can attend to broaden their medical knowledge. Most GPs take an interest in a holistic approach to their patients (social, psychological, physical). As matters stand GPs now refer to a borough 'Access and Allocation Team' with no one held accountable, and even though requested by the GP, a Consultant Psychiatrist's opinion is not always provided. Responsibility is the province of senior doctors and management and should not be diluted by putting pressure on the Team as a whole whose individual experience varies considerably. Doctors (and nursing staff) should have mandatory training in psychological therapies (cognitive and behaviour therapies specifically). A fixed number of sessions in addition to their usual duties could be part of the job plan for those doctors interested in the psychotherapies per se, or put another way, a holistic approach to patient care, which is what most doctors do in any event. Patients would then have the benefit of medical and psychological input simultaneously (let's call it a cognitive-medical model). Waiting lists would be dramatically reduced at a stroke and Trusts would no longer have the responsibility of finding and employing unqualified (in medicine or psychology) 'talking therapists'. People who are generally physically well and who do not have serious psychosocial problems or psychiatric illnesses could receive treatment elsewhere through their GP, counsellors or other psychotherapists (those with no medical or psychology degrees)

of their own volition. There is no need to clog up the system with 'customers'. We are not a supermarket!

Complaints will inevitably follow when patient dissatisfaction begins to emerge, which is only a matter of time. More serious incidents will be a consequence of too many bed closures and staff shortages. Dilution of responsibility means that no one person seems to be accountable when things go wrong and patients are left stranded (read the Francis Report [9]). Already GPs are frustrated by the lack of informal contact with psychiatrists who are once again seen to be retreating to their ivory towers, having been overwhelmed by lots of courses, lots of training, lots of meetings, lots of empty rhetoric. Too much emphasis nowadays is placed on the sociological/psychological aspects of patients' illness and so serious conditions are missed. GPs should be able to refer directly to their colleagues where there are immediate concerns and not have to wait for triage meetings which delay this process. After all, GPs know their patients best. Community clinics could take the bulk of moderate conditions (which are causing undue stress) and see patients for as long as necessary (not a determined number of appointments) before deciding the GP can resume responsibility. 'Packages of Care' and other outdated expressions should be confined to the dustbin. Patients are not fooled by promises of cardboard boxes with little pink ribbons. Continuity of patient care requires a flexible approach which encompasses easy access to information and a direct pathway to services and medical care when needed.

Knowledge in the making

Psychiatrists should concentrate on more difficult and complicated cases (as was the case in the past) as well as routine moderate conditions, enabling them to use their broad skills more efficiently and effectively. Some psychiatrists see too few patients and this should be changed. Perhaps there is a case for psychiatrists rotating through some specialties say, every five years, for example, between Rehabilitation and General Adult Psychiatry. There are many patients who are not on mood stabilisers or clozapine who require intensive input and combined medical expertise and rotating between posts would offer valuable experience. A more varied approach is thus needed but do we really need all those subspecialties? What ever happened to the general psychiatrist with a special interest? In our view at least one year of neurology training should be mandatory for psychiatrists during their training. No formal examinations, just certificates to prove the courses have been completed; otherwise the system grinds to a halt. Under this system a doctor could still theoretically become a consultant after nine years postgraduate training (three years in foundation training and neurology), and six years Psychiatry (to include neurology, psychology and sociology) which is not unreasonable. Equal emphasis on neuromedical, sociological and psychological factors causing health problems would foster a healthier and friendlier relationship between disciplines which deal with mental illness and primary care providers. As it stands, with the fragmented role of general adult psychiatric services and the emphasis on e-learning and internet training for junior doctors (no hands-on clinical experience) we are facing yet another era of overemphasis on social psychiatry (or rather reverting to ancient belief systems) with its 'neutral' politically correct denigrating sound bites (customers, clients, service users). All will be well if we can just sort out the social problems! The simplistic notion that problems will disappear if we do not smoke, drink, take illicit drugs, keep our weight down, and have a home to go to, is the stuff of social engineering by the 'experts in living,' and alas by doctors who have lost touch with medicine.

Doctors need reminding that psychiatry is that branch of medicine that is concerned with the study, treatment, and prevention of mental illness using medical and psychological therapies as well as paying special attention to social hardship and isolation where present. It is not philosophy or social science. It is to medicine what metaphysics is to philosophy. Psychiatrists need to broaden their horizons and take their heads out of the therapy books to witness the advances in neuroscientific techniques and genetic advancements that have already transformed the nature of medicine. To develop their psychological skills they need to take on board that patients want more than drugs to alleviate distress. Therefore practical techniques such as CBT or DBT (dialectical behaviour therapy) will further heighten their expertise as physicians. Many doctors are already familiar with applying CBT and other therapies. However, doctors should also be aware of the limitations of psychotherapies in general, recognizing and acknowledging that such therapies do not always work either and indeed in some instances may be harmful. Psychiatrists should be part of separate Wellbeing Clinics (perhaps one session per week) to becoming better acquainted and proficient again with physical examinations, investigations, routine procedures (ECGs for example) and interpretation of results (not just screen, but to intervene). This overseeing of the physical health of patients is not always possible in a busy outpatient clinic. Many potentially serious conditions would be revealed and information to the GP or tertiary services made known immediately. Psychiatrists are not 'stuck in a medical model' no more than a physician believes all myocardial infarcts are caused by psychosocial factors or life style. But to ignore the medical advances in molecular biology and neuroscientific diagnostic techniques portrays a profound ignorance of biological psychiatry and is insulting to those scientists who work tirelessly, often without much recognition, to further our understanding of 'brain disorders'. It is all very well to talk about art, philosophy, social sciences and literature as having a great bearing on our interest in psychiatry and congratulate ourselves as 'lateral thinkers' but an understanding of the philosophy of say, Bertrand Russell or indeed the school of Zen Buddhism, will not eliminate mental disorder. Romantic as it might sound in retrospect, Vincent Van Gogh did not enjoy cutting his ear off, nor did Robert

Schumann feel ecstatic when jumping into the Rhine before being carted off to the asylum.

If we do not embrace a holistic view of mental ill-health we risk not only throwing the baby out with the bath water but the bath itself, thereby causing further dissatisfaction and low morale among doctors with an inevitable negative impact on patient care. Psychiatrists are not bemoaning their loss of hegemony - a favourite word and another myth propagated by the antipsychiatry lobby; rather, it is only too obvious to them (as qualified medical doctors) that patients will suffer in the long term by not being referred appropriately to those who have the expertise to recognize and distinguish between human difficulties and illness. There is also a need to re-examine the impact of psychological therapies and not succumb to the popular and naive notion that they are all evidence-based in scientific terms. In the meantime the 'worried well' can indulge themselves with all the peripheral talking therapies and current fads they desire. Likewise, performance management, outcome measures and payment by results have become relentless tick-box exercises creating unnecessary stress among health care professionals (threats of job losses) who 'must meet targets at all costs', all for a slice of the Commissioners' cake. What a way to run a health service! Patients become meaningless statistics in the meantime. No! The wake-up call should be aimed at those who are intent on destroying the good will and values of the very same people they purport to support, through their social engineering and outdated attitudes.

Competing Interests
None declared
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