General psychiatrists discovering new roles for a new era . . . and removing work stress

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The College last reviewed 'The Responsibilities of Consultant Psychiatrists' in 1996, noting with concern "reports of excessive workloads being undertaken by consultants" (p. 7). Some causes and consequences are apparent in the high levels of premature retirement and consultant vacancies (Kendell & Pearce, 1997).

A large questionnaire survey in Wessex (Rathod *et al*, 2000) confirmed that long hours and 'on-call' interfering with family life are common causes of moderate to extreme stress. A large audit in north-west London concluded that case-loads of consultants in community teams are too large to allow them to exercise the statutory duties of a responsible medical officer and, therefore, need revision (Tyrer *et al*, 2001).

There is literature from Australia and the USA on developing professional roles for the kind of community services that we are about to inherit from them in the National Service Framework (e.g. assertive outreach, home treatment). The few studies that have been done on the work of psychiatrists in this country are long on problems but short on solutions. It is suggested that large systematic surveys are not the best way to identify innovators who might hold keys to a better future. The Davey lamp was not discovered by a survey of miners and coalmines, and nor will questionnaire studies tease out the reasons why consultants under pressure are unable to change things for the better. We illustrate here how qualitative research with a small and selected sample of consultants may be more revealing in these respects. We report, briefly, the solutions that some general psychiatrists have found and the complexity of reasons (internal attitudes and external constraints) why other general psychiatrists have been unable to make similar adaptations.

The sample of 26 consultant general psychiatrists were recruited by a snowball method. The first person interviewed was asked to identify one or two others, either because they seemed under some work stress or because they seemed to be doing things differently and perhaps more successfully . . . and so on.

In-depth interviews with these consultants, all in the Northern and Yorkshire Region, produced an analysis that they all later endorsed. It has stimulated interest in the ways in which some of their number are forging new roles more suited to the conditions of today. Chief executives of mental health services in the Region have welcomed the report (Kennedy & Griffiths, 2000), recognising that getting things right with general psychiatrists is essential for implementing the National Service Framework.

TRADITIONAL ROLES UNDER STRESS

The rise in emergency referrals over recent years, combined with government and public expectations of risk avoidance, has conspired to make the jobs of many consultant general psychiatrists close to impossible. A typical story is detailed below.

Consultant T (for traditional)

> "The consultant sees personal referrals from GPs [general practitioners] and accumulates patients with whom individual members of the CMHT [community mental health team] say they cannot cope. There are several portals of entry to the specialist services (consultant, CMHT, psychologist etc.) so any renegotiation of referral protocols is complex and difficult. Personal case-loads are high (and still rising): currently there are on average 3+ new out-patients and 25+ follow-ups per week. There are on average 10 in-patients to be seen regularly on the wards. Hence, fixed sessions have risen to seven or eight per week and the consultant's interest in post-graduate training is being squeezed out. It is a real struggle to find time to respond to the increasing emergencies and patients are admitted without specialist assessment. To protect fixed sessions, the consultant may defer seeing emergencies to the end of the day and therefore gets home late, exhausted, and worried that risk assessments have not been thorough enough . . ."

We found far too many consultants trapped in situations like this, working up to and over 60 hours a week and describing their job satisfaction as less than 20% and falling. They tended to be in trusts where there was low engagement between consultants and senior management, and where no attempt had yet been made to establish an individual review system, including the monitoring of workload.

EMERGING NEW ROLES

The very wide variation in workloads and practices was a striking finding. We found a number of consultants at different stages of change towards new roles. At opposite ends of the spectrum are the 'adapted traditional role' (AT) and an 'emergent new role' (N). Both are characterised by much clearer separation of fixed sessions from emergency work and both have been developed with close understanding and support from chief executives.

Consultant N (for new)

> "This consultant has an inner city population of 40,000 and is busy but not overloaded. The consultant operates from within a large CMHT of 20 professionals – the CMHT is regarded as the work base with lots of scope for delegation. There is only one portal of entry to the service through referral to the CMHT, where allocation of work is decided at a weekly meeting. The consultant delegates a lot and sees personally 0–2 new patients per week. Up to 20% of GP referral letters are returned with advice from the CMHT member who liaises with the particular practice. (A consultant with a similar overall approach in a rural area does clinics in health centres and is renegotiating referral protocols directly with GPs.) The weekly number of follow-ups is relatively low (around 15) and most of these are reviews with key workers. This consultant has no more than 5 fixed sessions and will delegate more to preserve this balance so that s/he can respond quickly in support of other professionals dealing with crises. Patients therefore are less likely to be admitted without express approval of the consultant, who has relatively few in-patients, ranging from 2–5. Time spent on the ward is also less, because the ward manager can be relied upon to manage the care programme and prepare the patient for discharge as soon as possible. The job is viable and stimulating because there is an excellent working partnership with a sector manager, and both have direct access to the chief executive."

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Consultant AT (for adapted traditional)

> "Some consultants are adapting the traditional role by negotiating clearer separation of their fixed sessions from emergency work. Partnering with a consultant N in the same sector is one option, where Consultant N deals with all emergencies whilst Consultant AT has plenty of protected time to deal with a greater proportion of the fixed sessional work required. Consultant AT covers absences of Consultant N by much reduced fixed commitments on those days. This works best when 'AT' accepts the single point of referral through a CMHT and the two consultants manage allocation of work together. Large rotas of consultants are another option where the day or week 'on emergencies' is booked with no other commitments. The rest of the time is uninterrupted by emergencies."

These different jobs are equally valuable to the service. At different stages of an individual's career one option may be preferred to another. We are all trained sufficiently for the 'AT' role. Opportunities for developing into the 'N' role could be provided. The crucial point is that trusts may need more consultants to take on the 'N' role if sector services are to develop well, if there is to be a single point of entry, as the National Service Framework requires, if the overcrowding of in-patient wards is to be reduced and if workloads of consultants (both 'N' and 'T') are to be reduced.

CONTROVERSIAL ELEMENTS OF CHANGE

Internal misgivings sometimes prevent consultants from adapting or changing their roles, as well as a lack of the supportive context required from chief executives and other professional colleagues.

"GPs have a right to expect me to see personal referrals and this close consultant/GP relationship is good for patients". But their colleagues will argue that GPs and their patients prefer the new arrangement when they find that a single route of entry to secondary care services through the CMHT ensures that the patient is seen more quickly, by the right person, with the time and ability to deal with their problems. And CMHT professionals avoid wasting time on repeat assessments with delays in passing patients on to the colleague best able to treat them.

"As RMO [responsible medical officer] I have legal responsibilities which restrict the degree of delegation that can be allowed". Colleagues who do delegate a lot will say that they have the full backing of their chief executives and trust boards, as well as the support of professional colleagues to whom legal as well as clinical responsibility is delegated. The amount of delegation is, of course, dependent on the capacity and expertise in the rest of the mental health team. Chief executives will point out that they too have accountability to parliament for the quality of care for every patient referred to their trusts, and that responsibility is discharged by ensuring adequate systems of delegation and monitoring. No individual professional can ensure total quality. The consultant's greatest contribution is with the more complex and difficult patients, for whom they need time.

All the consultants interviewed had some difficulty in responding to the question: "What are the primary responsibilities of a consultant general psychiatrist?". The one thing on which there was complete consensus was that 'the buck stops' with the consultant for handling patients with serious mental illness and complex needs and who may present high risks. The consultant's sapiential authority and leadership stem from such responsibility, and in well-functioning trusts this is fully recognised by chief executives and other professionals. Where it is not recognised, there is unconstructive tension between consultants, managers and other professionals.

There is a very strongly felt perception that the division of work between general psychiatry and its sub-specialities has been unfairly developed and maintained. Rehabilitation, forensic psychiatry, substance misuse and psychological therapy services have been set up with their limits defined unilaterally. These sub-specialities are allowed to say who they treat and who they do not. Quite a lot of work was done in setting them up to resource them for this purpose. General psychiatry has not had the same privileges. Because in many trusts there are no good mechanisms for resolving differences, there is intense frustration with regard to felt or real exploitation. It was one of the strongest recommendations to chief executives from general psychiatrists – that mechanisms must be found for achieving bilateral agreement on interfaces if they are to recruit and retain committed general psychiatrists in the future.

ACTION

The psychiatrists were surprised how little they knew about how other general psychiatrists were tackling the job. We have identified 'role models' for consultant 'N' and 'AT' jobs. Consultants have expressed interest in joining 'learning sets' where new roles can be explored in detail, as well as the context that needs to be provided by chief executives and trusts in order for them to develop.

At the request of the consultants and chief executives, we are now designing an implementation process that will start with a pilot audit in one or two trusts, leading to a local action plan. Much is in the detail of local service needs and the aspirations of local consultants. Sensitive work with local GPs and other affected professionals is essential. Their understanding and agreement are necessary in order to make progress.

CONCLUSIONS

Credibility for the results of this exercise derives from the fact that new roles for the new era have been invented by the consultants themselves and are being practised with the cooperation of other professionals. We thank the 26 consultants who took part for all the thoughtful reflections on their jobs. Although they were a small and deliberately selected sample, the analysis of their concerns and the action that we propose in trusts have found general support from audiences of psychiatrists across the country. It is not suggested that the particular solutions or role models identified in this study are the only ones worth considering; rather, we recommend

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the qualitative method used to identify and study novel practices. Parallel studies are needed on the roles of ward managers, nurses and other professional members of community teams.

DECLARATION OF INTEREST

The Northern Centre for Mental Health is funded by NHS trusts in the Northern and Yorkshire Region with mental health services.

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