Anthony (Tony) Whitlock arrived in Brisbane, Queensland in August 1964 to find a University, a teaching hospital and a medical fraternity eager, though a little apprehensive, for the psychiatric leadership that only the first incumbent of the new Chair of Psychological Medicine could provide. From the daunting initial task of teaching undergraduates in the grossly overworked Brisbane General Hospital Psychiatry Department (dubbed 'a snakepit' and 'medieval' by the press), he gradually developed a substantial department which, although eclectic, always retained a solid biological perspective.

In Brisbane he continued the earlier work he had begun in Newcastle on suicide and suicidal attempts. Later his recognition of the extensive abuse of barbituates led to extensive educational programmes which significantly reduced their use. Traffic accidents, alcohol related illnesses, hysteria, epilepsy, the Ganser syndrome, forensic psychiatry, multiple sclerosis and psychophysiological aspects of skin disease all came under his researcher's scrutiny.

He instituted post-graduate teaching, and revived the almost defunct Diploma of Psychological Medicine of the University of Queensland. Later, however, the Royal Australian & New Zealand College of Psychiatrists became the examining body for psychiatrists, and he was then content to let the DPM disappear.

Professor Whitlock was always ready to contribute to the Royal Australian and New Zealand College of Psychiatrists in whatever way was asked of him. He presented the Squibb Academic Address at the College's Annual Congress in Adelaide in 1976. His research work was recognised by being the first to be awarded the College's Organon Senior Research Prize in 1978.

In his last year in Queensland he developed a large meningioma which was successfully removed. His retirement to Cornwall was marred by several recurrences necessitating further surgery, although he enjoyed teaching post-graduates there for several years.

Seventeen years spent in Brisbane did nothing to diminish two of his greatest gifts, the elegance and clarity of expression of what he said and wrote. His was, in fact, a seminal and fundamental role in establishing psychiatry as a clinical and academic discipline in Queensland where patients, doctors, psychiatrists and health services continue to owe him much.

JL
JP

Dr John Bowlby

The Memorial Service for Dr Bowlby will take place on 8 January 1991 at 11.30 a.m. at Southwark Cathedral.

An obituary for Dr Bowlby will appear in the January 1991 issue of the *Psychiatric Bulletin*.

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Comment

Department of Health: developing districts

Robin Cook has said that a Labour Government would retain the central plank of the White Paper – contracting. Contracting can work only if the health authority "purchaser" is separate from governance of hospital and community health services. This Department of Health document outlines the process of setting up the new district health authorities. Psychiatrists need to be thinking out the opportunities and the risks to their services. It will take at least five years to get the new system fully working.

Psychiatrists who have watched the budget for their "priority service" cut, year after year, to pay for uncontrolled growth in the Acute Sector should see contracting as an opportunity to ring fence the mental health budget. Psychiatrists who are overwhelmed with referrals, such that they are suffering from overwork and their patients from reducing quality of care, now have an opportunity to start negotiating what volume of new referrals can be managed with reasonable quality of care within the

available budget. It is remarkable that the Health Service has got so far with hardly any data on what specialties actually do. The new health authorities will want increasingly detailed information on what conditions are being treated and then to agree priorities and perhaps exclude conditions for which there are marginal benefits.

The notion that health authorities have a lot to gain for their populations by studying treatment outcomes may apply to the acute sector. Estimates (very crude) suggest that below 30% of interventions are of real benefit. Psychiatry is more about crisis management, a few established treatments, and highly skilled care. Therefore psychiatrists might be reassured rather than perturbed by this new emphasis if it tempers the escalating costs of acute services which constantly threaten the mental health budget. Since as much as 25% of a district budget can be spent on people who are dead within 12 months, they might want to be involved in the examination of what expensive heroic physical treatments can be replaced by more appropriate palliative methods of care that give higher priority to meeting psychological needs.

Because psychiatric services are largely territorial, psychiatrists are not in competition for contracts with psychiatric services in other districts. However, they should not see themselves as monopoly providers. We have already seen continued care of the elderly and mentally ill shift to the private sector and voluntary organisations have taken on a major part of the services for alcohol and drug abuse. The purchasing authority will be interested in any proposal to shift work and resources from secondary to primary care, where often more can be treated for less.

The purchasing DHAs have to regard general practitioners as their major customer, on behalf of the patient. General practitioners are already making it clear that they want more flexibility in referral to consultants within sectorised services. It is a fact of life that GPs have different views on priorities from hospital doctors. They may well favour more being spent on geriatric and psychiatric services at the expense of high-tech surgery and medicine, but not necessarily in services run by hospital-based psychiatrists. Psychiatrists in each district need to be talking together to get their advice clear on the essential requirements of a quality psychiatric service against which any proposal for change must be tested.

The reason politicians across the spectrum want to see this system work is because it invests in the new authorities all the political, ethical, value-ridden dilemmas of what is treated and what is not, thus distancing some blame from central government. It is a move to shift some of the emotionally charged rationing decisions out of the consulting room and to make consultants collectively accountable for carrying out what is agreed in the contract. Consultants are understandably very uneasy about contracts that tell them what work to do. I do not believe a contract will be worth the paper it is written on if it does not reflect what the consultants concerned believe is the best use of their time and skills. I believe health authorities will be desperate to ensure that consultants and GPs have been so intimately involved in the negotiation of priorities and change that they will be publicly supportive. Now that everyone is waking up to the fact that health care is "rationed" people expect it to be done well. Here is a mechanism with the potential to do it better. At present the individual consultant has no means of agreeing priorities with several colleagues and perhaps 200 referring GPs. This results in great inequalities which are increasingly apparent and unacceptable.

The East Anglian simulation exercise on how this new health care system might work surprised everyone by revealing a stronger tendency for the purchasing agencies to compete than provider units. The health authority, local authority and GP fund holders were pulling in different directions, striving to get more volume of care, often at the expense of one another's clients, and without evident commitment to an integrated quality service. Everyone has been so obsessed with self-governing trusts that the need for clear objectives and regulation for purchasing authorities went unnoticed. Regional general managers, in particular, now have a major task to regulate in order to avoid this outcome. Psychiatrists should be vigilant to ensure that their DHA and local authority explicitly agree appropriate common service objectives and common quality standards and have good monitoring systems with which to ensure that they are achieved. Failure here is, in my view, the greatest risk of all.

Psychiatrists have long been moving towards a collective commitment to running a local service, and so the introduction of service agreements might not be too problematic. They will find the relationship with their managers less complicated. The latter will no longer have to be schizophrenic, trying to hold down costs and meet the aspirations of consultants at the same time. Both will share the same objective to persuade the purchaser that extra work must be matched by adequate resources in order not to compromise quality of care. The argument will be more specific about what extra cost, and probably more persuasive than the tired old battle cry of "under-funding". Kenneth Clarke has said that no-one now doubts that the NHS will require substantial increases in funds and a greater proportion of GNP over the next decade.

PETER KENNEDY

District General Manager
Bootham Park Hospital
York YO3 7BY

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