Future nursing participation in the appointment of consultant psychiatrists

DEAR SIRS

I must say I was fascinated by Dr McLean's suggestion regarding future nursing participation in the appointment of consultants (*Bulletin*, March 1985, **9**, 62). Might I ask why should the arrangement stop at a nurse representative? Why not include a psychologist, social worker, occupation therapist, porter, domestic and, indeed, perhaps a member of the garden staff—all of whom can also play an important role in treatment and management?

The discussion which takes place at Dr McLean's divisional meetings suggests an early dementing process can affect not only the individual but, it also appears, some groups. Perhaps one should not be so unkind or reactionary and accept that the imminent onset of Spring does allow some licence for silly ideas of this nature. Wake up Dr McLean to the implication of your suggestion upon the medical profession, the National Health Service, Unit Management and the service we give to patients.

I would like to suggest some items for the agenda of your next divisional meeting: e.g. (1) Our heads are in the clouds! How did we get here?; (2) Divisional disbandonment and early retirement on nursing representative recommendation; (3) Nursing advice on early retirement of doctors—is such acceptable?

If nurses are to participate in consultant appointments, can they not also have a voice on when consultants retire?

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DEAR SIRS

Elizabeth McLean (*Bulletin*, March 1985, **9**, 62) asks for our comments on her suggestion that a nurse should sit on consultant appointment committees. Well, I think that she is wrong.

These committees need to be kept small and should consist of members who can truly assess each candidate's knowledge, experience and potential. A senior psychiatrist will certainly assess a candidate's ability to work alongside nurses, recognizing the important role of the latter (and of many other workers) in the team. It is also necessary to assess a potential consultant's ability to give leadership in such a team.

It is surely extending the multidisciplinary idea to ridiculous lengths to demand a nursing 'voice' at what must be a very specialized professional occasion. And where would one draw the line? Why not psychologists, social workers and paramedicals of all kinds?

The ultimate 'responsibility' for medical care is not 'shared'—it is that of the consultant. Future consultants should be appointed by those able to assess their competence as psychiatrists and not by a multidisciplinary panel.

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DEAR SIRS

Dr Elizabeth McLean's proposal (*Bulletin*, March 1985, **9**, 62) that a nurse should be included on Advisory Appointment Committees for Consultant posts does not go nearly far enough.

I would suggest that such Committees should include a nurse; a social worker; an occupational therapist; a clinical psychologist and an administrator from each of the 'sectors' in which the successful candidate will have to work; and a representative of the appropriate Community Health Council. Membership or Fellowship of the Royal College of Psychiatrists would be a disqualification, though the presence of a psychiatric trainee might be considered.

Further regulations should require the person appointed to abide by the decision of the multidisciplinary team in all matters. Responsibility in the event of any mishap or complaint would, however, remain firmly with the consultant concerned.

I. G. BRONKS

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DEAR SIRS

I wish to support Dr Elizabeth McLean's suggestion that we press for nursing participation in medical appointment committees in the specialty of psychiatry (*Bulletin*, March 1985, **9**, 62).

The regulations already allow authorities to appoint one or more additional members to the committee where 'the person to be appointed will be required to carry out duties on behalf of a local authority' (NHS (Appointment of consultants) Regulations, 1982, Schedule 4, Regulation 7(1) and 7(2) and 1(i)).

This has enabled a number of appointments committees to include non-doctors, such as social workers or psychologists, which is a start.

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The 'ivory tower' vs the 'poor nation of others'

DEAR SIRS

As another 'ivory tower' incumbent who was until recently looking at the psychiatric world from the same side of the fence as Drs Nehama and Launer, I would like to point out the utter nonsense of David Goldberg's 'table of workload' set out in his letter (*Bulletin*, April 1985, **9**, 83). Without any reference to the relative sizes of the catchment areas of Prestwich Hospital and the University Hospital of South Manchester, or the contrasting demography of the two areas, he goes on to suggest that somehow his unit gets through more work. He compares numbers of medical staff which are roughly equal in the two hospitals but omits to mention that Prestwich is a vast, old mental hospital of 1,400 beds with a large long-stay population, whereas the small university unit at Withington started afresh with no long-stay patients. Withington has *double* the

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ratio of nurses per patient, *quadruple* the number of psychologists, *double* the number of doctors. Furthermore, the doctors do not have to spend their time providing a service to enormous numbers of long-stay patients.

What really made my blood boil was Goldberg's proud claim that 45 per cent of the patients in his unit come from outside his own district. I hope his District Health Authority is happy about him spending half of the district money earmarked for local people on others. We all know who these 'imported' patients are—middle class people with, on the whole, fairly minor psychiatric illnesses who have a good prognosis and who are prepared to travel for the cachet of teaching hospital treatment—no patients with chronic schizophrenia, no dementia, no chronically impoverished alcoholics, no teenage drug addicts, no one old. This is a comfortable way of practising psychiatry and most teaching hospitals do it—but they ought to be ashamed of themselves. What a pity teaching hospital units do not spend their money and time providing model services for their own districts and caring for those severely ill psychiatric patients most in need.

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DEAR SIRS

I write as spokesman for the consultants at Prestwich Hospital to express our anger about the letter written by Professor Goldberg (*Bulletin*, April 1985, 9, 83). We hope that you will publish this not as part of any local quarrel, but as part of the tension, both in psychiatry and other specialties, between peripheral hospitals and teaching centres.

We do not doubt at all that the UHSM does a very large amount of excellent clinical work. What we resent, however, is the quotation of figures that are spurious and suggest that there is parity of resources between the two hospitals.

Prestwich is a large psychiatric hospital with 800 long-stay patients, over and above those at the UHSM. It is not therefore surprising that the hospital has more nurses and more total therapists. It has regional responsibilities with consultants in charge in psychotherapy, drug addiction, adolescents and a very large regional forensic unit so that there are eight more consultants at Prestwich doing work which is not represented at the UHSM. The busiest admission unit in Salford, which is run in tandem with Prestwich, is the unit at Hope Hospital. If Hope figures were taken into account, there would be at least as many acute admissions in Salford as at the UHSM. The bulk of the Salford out-patient work is done at Hope Hospital and in health centres, so that out-patient figures cannot be compared. The bulk of Salford day patient attendance is in local authority day centres, which again are not mentioned in Professor Goldberg's letter.

In the areas of general psychiatry which *are* directly comparable, there are five and a half consultants at Prestwich and four generalists plus a professor and half the time of four senior lecturers at the UHSM. Only three psychologists at Prestwich do acute work, but twice as many do acute work at the UHSM. Prestwich has far fewer occupational therapists than the UHSM. At Prestwich, acute patients are looked after by SHOs with the help of one part-time assistant psychiatrist. At the UHSM, the acute firms have both registrars and a senior registrar on each.

While there is a very great deal of research and teaching at the UHSM, it is nevertheless a fact that three of the general psychiatrists at Prestwich also teach undergraduates and have also recently published research in the *British Journal of Psychiatry*. You will remember that one of our general psychiatrists is the editor of your parent journal!

Professor Goldberg regards it as creditworthy that nearly half of the acute work at the UHSM comes from outside its boundaries. It is, of course, usual for centres of excellence to attract from afar. It does, however, seem strange that the UHSM should routinely serve much of Trafford, Stockport, commuter Cheshire and proximal Derbyshire. It would appear to be more sensible if these latter districts were to improve their facilities so that their residents could be looked after nearer home and the UHSM could devote its substantial resources to blazing trails in other fields.

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'Trisomy 21'

DEAR SIRS

I should like to draw your readers' attention to a new journal, *Trisomy 21*, which will shortly be appearing. This journal is under the editorship of John L. Hamerton of the Division of Human Genetics, University of Manitoba, Winnipeg, Canada, and my own role is that of Associate Director dealing with European contributions.

The first edition includes a review of cell therapy in the treatment of Down's syndrome, as well as papers on obesity, play, genetic studies, and US speech and language pathology services for Down's syndrome people in the USA.

The Editor is anxious to institute a series of invited mini-reviews on topical subjects related to the study of Down's syndrome. Such reviews should be in new areas of research, care or training and should be written with the intention of interpreting new findings to the non-specialist audience. He proposes inviting such reviews from time to time and if any of your readers have ideas as to topics or authors, Dr Hamerton would like to hear from them. Two mini-reviews have been invited for future issues, one on Animal Models and the other on Somatic Cell and Molecular Genetic Studies on Chromosome 21.

Manuscripts should be submitted to: John L. Hamerton, D.Sc., F.C.C.M.G., Division of Human Genetics, University of Manitoba, School of Medicine, 250–770 Bannatyne Avenue, Winnipeg, Manitoba R3E OW3, Canada.

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