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PHILIP TIMMS

The consultant psychiatrist – a remembrance of things past?

The guilt seems to have rubbed off the gingerbread for the three members of our local community consultant group. We have senior lecturer contracts, have worked as consultants in inner London for 10 years and might be expected to be secure and content with our respective lots. Yet, we find ourselves increasingly uncomfortable with our place in the scheme of things.

We could just be dissatisfied doctors. Psychiatrists are reported to have retired early because of increased workload and loss of control over their work (Kendell & Pearce, 1997). We experience many of the pressures that lead to unhappiness, psychological distress, alcohol abuse and suicide in doctors generally (British Medical Association, 2000). However, there may be more to it than this. A recent survey of general psychiatrists (Kennedy & Griffiths, 2000) has highlighted problems experienced with role ambiguities and we have become interested in one of these. We just don't feel like consultants. We are not sure what it should feel like, but we do know that cognitive dissonance is bad for us. So we have tried to consider what a consultant might be, should be, and even whether it has ever been a helpful model for psychiatry.

So, what is a consultant?

The *Oxford English Dictionary's* definition is: 'a consulting physician . . . who is called in by colleagues, or applied to by patients, for advice in special cases'. The traditional consultative model is still widely held, but has its origins in the Edwardian era of the charity hospitals. A consultant would regularly visit a hospital to teach, run ward rounds, conduct particularly difficult operations or see perplexing cases. He (rarely she) was used sparingly for his expertise and experience and would be paid little, mainly deriving status from his position. He would earn the bulk of his living from private practice. He was, literally, consulted. He came and went, but the resident hospital staff supplied the bulk of continuing therapeutic work. This

model worked for several reasons. Effective interventions were few and comparatively simple, so most could be delegated. Society was more deferential and the attention of the consultant was seen as a privilege, not a right. This model of detached, expert care held mainly for those of modest means and for the poor. Private patients would receive more regular and continuing care. Medical provision reflected the social strata of society. Individual and continuing attention for the well-off; intermittent, pro bono advice for the poor. His detachment from the humdrum and his socio-economic alignment with the upper classes gave the consultant an aura of prestige, power and distance.

During the 1930s, consultants became more a part of the hospital, but they were not paid their full worth and were expected to run substantial private practices. In 1948, Aneurin Bevan confronted the reluctance of the consultants to be absorbed into the socialistic enterprise of a National Health Service (NHS). His cynical but clear-sighted decision to 'stuff their mouths with gold' (Abel-Smith, 1964) dragged them in. Consultants they remained, but there had been a fundamental change in their position. No longer independent contractors, they were now, for at least part of every week, salaried employees. However, in many respects, they still behaved more like independent contractors. The notion of complete clinical independence was maintained, with no expectation that a consultant should be supervised in any way at all. This gave rise to the impression, and sometimes the practice, of waywardness – the consultant could do what he or she liked without reference to the rest of the system. The air of detachment and privilege persisted. The consultant was part, and yet not part, of the NHS health team. One irritating manifestation of this semi-independent status was the right of the consultant to continue in private practice, often in NHS time, on NHS premises, with NHS staff. Consultants were respected for



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their skills but, in a society with increasingly democratic expectations, resented for their privileges.

Today, consultant psychiatrists are expected to be an integral part of the local psychiatric service. It is only in private practice that the old notion of the independent consultant still holds true, and the line between private and NHS practice is clearer. NHS consultants now have obligations wider than the development and exercise of their own clinical skills. Commitments to audit, education and the supervision of junior doctors pull us further into the core of our local services. Clinical governance makes us directly responsible to our employers for the quality of our clinical performance. We are now involved in providing a continuum of care rather than sporadic interventions, and tend to work well beyond our contracted hours for the NHS (Office of Manpower Economics, 1998).

It is not only service arrangements that have changed. As a society, we are less deferential and feel that everyone is entitled to the best possible care. If the most expert person in the team is the consultant, that is who we want to see. If we listen to our patients, we hear that they have similar expectations. They want to be seen regularly by the same doctor, 'my consultant', not by a succession of rotating trainees. On the whole, our patients want what we would want in their position – consultant-level expertise applied to their 'routine' clinical situation. This fits with the increasing sophistication of interventions for people with severe mental illness. The wider range of medications available generates more complex choices. We are now aware of effective, evidence-based ways of talking with our patients, which cannot be so easily delegated as the cursory reviews of depot medication that I remember from my days in training.

This model of service seems best to fit the notion of the psychiatrist as a 'senior specialist', providing a continuing and personal service. It is also reflected in the notion of the consultant-led service, described in policy documents concerning future developments in medicine (NHS Executive, 2001). Here, the consultant is described as being 'at the forefront of service delivery, maintaining a high degree of patient contact and bearing the greatest burden of high-intensity working patterns'. The NHS Plan makes clear the preference for 'a consultant-delivered service' (Department of Health, 2000). This is the crux of the matter. If the consultant applies his or her skills and experience to every patient, the consultative function vanishes. We are not guiding, advising and deputising the work to someone else, we are doing the work ourselves and acting as senior specialists.

Within psychiatry, most discussions have assumed the consultative model of practice. The recent document from the Faculty of General and Community Psychiatry on the roles and responsibilities of a consultant in adult psychiatry (Royal College of Psychiatrists, 2001) discusses matters other than direct contact with patients. A recent proposal to modify job descriptions for consultants to fit the current resource shortages (Kennedy & Griffiths, 2000) has suggested something more along the lines of the traditional consultant model. These discussions have

avoided consideration of the quality and quantity of direct patient contact, but have rather focused on managerial, leadership, consultative and educational issues. Jim Watson took a different line, stating 'the simple proposition that "seeing patients personally" is the basis of clinical psychiatric practice' (Watson, 1985). This raises the question of whether the traditional consultant model has ever really been appropriate for psychiatry. Some specialities, particularly surgical ones, lend themselves to occasional, brief assessments and interventions. Ours does not. If the focus of our activity is to be time spent with patients, we are performing a role that is nearer that of the psychotherapist than the traditional medical consultant, whether or not we are carrying out formal psychotherapy. The NHS Plan includes both direct-contact and consultative models, describing them as stages in a consultant's career. '... in the early and middle part of their careers, consultants will be expected to devote the bulk of their time to direct clinical care... towards the end of their careers... we envisage a greater role for mentoring, training and leadership' (NHS Executive, 2001).

Our position as consultants is not the same now as it was 40 years ago. We have many new responsibilities and few of the privileges of the *ancien régime*. We are caught between two very different models of service. Our title suggests a traditional medical/surgical consultative model of service. This is promoted by the Royal College and accommodates the current shortage of psychiatrists, but it implies a portfolio of privileges we no longer enjoy. In our practice, we experience a primarily direct-provision model. This is nearer a psychotherapeutic or general practitioner model. It is what most of our customers want and it is being promoted by the Government. However, it is not achievable with current resources. We do regularly act in a consultative fashion, but it is not the defining quality of our work.

What to do?

We could stop being consultants and call ourselves senior specialists. This would help to cast off the obsolete attributes of privilege and unaccountability that still surround us. However, it might also disperse the more positive attributes of diligence and expertise that still adhere to the notion of the consultant.

It might be more immediately helpful to use these two different models to establish more precisely the expectations of our users, colleagues and employers, and to highlight some of the impossible expectations that are laid upon us. Our users, colleagues and employers will have to decide exactly what they most want from us, and what they will have to do without.

We have less than half the number of psychiatrists per head of population than any other country of comparable wealth (Muijen, 1993). If our society wants a service where most patients are seen by consultants, it must provide more consultant psychiatrists – but, perhaps paradoxically, consultants who are committed to a direct-provision model of service.



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Declaration of interest

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