Correspondence

Accountability and delegation

DEAR SIRS

It is not a coincidence that the professional press has, of late, carried statements of concern with attempts at clarifying the vexatious issues of consultant accountability, responsibility, authority and powers of delegation.[1-3]

The *Bulletin* (June 1987, **11**, 210–211) carried a report of a meeting of psychiatrists and psychologists, 'Working Together for Planning Services in the postGriffiths Era' in which statements on responsibility attributed to Professor Goldberg and Mr Steven Flett give grave cause for concern.

That the multi-disciplinary team has arrived to stay in medical practice is not questioned. That the multi-disciplinary team is an essential component of a good psychiatric practice is not in dispute. But by the same token of certainty is the fact that the named consultant in charge of a patient's treatment retains the ultimate responsibility for all aspects of medical care of a patient in his charge. These responsibilities for patient care are imposed by common and statute law.

The Council of the Royal College of Psychiatrists approved statements to this effect in 1984 and in 1986.[4,5]

The Joint Co-ordinating Committee of the three UK protection and defence organisations has said so in their representations and comments upon the Draft Code of Practice presented to the Secretary of State.[4-6]

The latest edition of the General Medical Council's pamphlet on *Professional Conduct and Discipline* gives advice on these topics in such a way that it would be unwise for any medical practitioner to ignore it.[7]

Perhaps a reiteration of other facts may be helpful in reminding ourselves of the true nature of the responsibility we carry as consultant medical practitioners in any designated health service.

The 1959 Mental Health Act introduced the term 'Responsible Medical Officer', now defined in Section 34 (i) of the 1983 Act as the registered medical practitioner in charge of a detained patient's treatment. The term 'Registered Medical Officer' is only applicable within the context of the Act and has no legal meaning outside this context.

Legal responsibility for a consultant arises either as a result of the terms of a contract or as a general duty of care (TORT). Under the National Health Service Act it is the duty of the Secretary of State to provide the services of specialists and it is the duty of Regional Health Authorities to make arrangements for the provision of medical services. A consultant contracts with the Regional Health Authority (not with the patient) to undertake diagnosis and treatment, and to provide continuing clinical responsibility for the patient, allowing for proper delegation to, and training of, staff. The phrase 'clinical responsibility' has no legal definition nor is it the equivalent of the legal duty of care.

A legal duty of care towards patients in hospital is owed by each separate individual employee, whether he be medical staff or a member of the ancillary staff. Furthermore, the responsible authority for a hospital is liable in law for the negligence of all of its staff, who are regarded as servants. The fact that the consultant has contracted with his employer to exercise 'clinical responsiblity' for a patient in no way affects or over-rides the duty of care owed by, say, the nurse to that same patient. The required standard of such care varies according to the skills and qualifications of the person–the amount of skill expected of a registrar would be greater than that required of a senior house officer but less than would be expected of a consultant. Liability, therefore, for any mishap will be attributed by a court to such one or more persons connected with that mishap whom the court finds have failed to exercise such reasonable degree of care as may be expected, in the circumstances of the case in question, and from such person or persons according to their training and experience. If there has been no such failure, then there will be no negligence and so no liability. The court is not concerned with 'accountability' in the managerial sense, provided that the consultant, in delegating any responsibility has exercised proper care in so doing.

For all patients admitted to a hospital there will be a named consultant in charge of their treatment. This consultant is regarded as being in overall charge for all aspects of medical treatment and he can delegate this duty only to a medical colleague. It is the consultant's duty to ensure that the resources of the hospital are made available so as to provide the range of clinical services his patient requires. When a patient is discharged from hospital or is treated as an out-patient, the general practitioner and the consultant should agree between themselves allocation of the medical responsibility.

In addition to receiving medical treatment, all patients will receive some form of nursing care and treatment and will receive also clinical services from other professional staff. It is increasingly the fact that non-medical professional staff possess knowledge and experience in diverse fields (e.g. nursing, psychology, remedial education) of which a medical consultant can only have a limited knowledge. It is thus often the case that non-medical staff are required to offer specific items of clinical treatment, and responsibility for the delivery of such items of service rests with the individual to whom referral has been made. He is expected to act responsibly within the terms of his own professional experience and training. Essentially, and importantly, each profession has its own competence and its members are responsible for decisions within their own sphere. This implies that members of each profession acknowledge the limits of their own competence.

It is encouraging for the continuing clarification and for the wider education of all professional colleagues that the Joint Standing Committee of the British Psychological Society and the Royal College of Psychiatrists intends to undertake to research organisational problems of this kind

that emerge inevitably from the principle of working together. Nevertheless, it is crucial that the committee starts its work with a thorough basis of the legal and professional frameworks within which each profession can work together with others.

J. H. HENDERSON

St Andrew's Hospital
Northampton

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When Approved Social Workers refuse to make applications for admission

DEAR SIRS

I feel I must reply to the letter by O. I. Azuonye in the *Bulletin*, July 1987, 'When Approved Social Workers refuse to make applications for admission'.

To be frank, this letter shocked and disappointed me and in my opinion it was at best misguided and ill-informed, and at worst ill-tempered and inflammatory. I fully realise that the Editors seek to stimulate discussion and include sometimes controversial and unusual letters but the inclusion of such a biased, unfair, and opinionated piece was mildly surprising to say the least. Perhaps one of the most serious and worrying aspects of the letter is that it purports to be the viewpoint of "most doctors" and "all those doctors who are regularly involved in the compulsory admission and treatment of patients". As I am "regularly involved" myself I am frankly insulted to have these viewpoints attributed to me and I feel it only fair to Dr Azuonye to set the record straight and correct certain misconceptions that he appears to hold. Moreover, I have shown Dr Azuonye's letter to an Approved Social Worker member of our team and I am most concerned that this type of diatribe will only serve to worsen relations between psychiatrists and our professional colleagues in social work.

I propose to challenge most of what is contained in Dr Azuonye's letter, piece by piece, on several grounds:

(a) Firstly, Dr Azuonye states that Approved Social Workers "have no training in the diagnosis and treatment of mental disorders". Where does he get this assumption from? It is utterly wrong. The only reason I can think of for this type of mistake is that Dr Azuonye is particularly unfortunate to work in an area with very poorly trained social workers indeed. This may be so but I hope he has checked his facts locally. The reason I am particularly annoyed about this type of inaccuracy is that I have taken a special interest in helping to train Social Workers at various grades here in Cardiff and South Wales and I have personal knowledge of the quality and intensity of training in mental health Social Workers receive, even from a very early stage in their careers. I have personally provided input to Social Worker training at undergraduate level, CQSW level (Certificate of Qualification in Social Work), and on courses to instruct qualified Social Workers to the level of "Approved Social Workers". A lot of time and effort goes into ensuring that Social Workers have exposure to, and training in, mental health issues in general and that they also have some formal instruction in psychiatry itself. The fact that they are not qualified doctors does not prevent them understanding many of the central issues related to mental health in the 1980s and in my opinion many of them are more enquiring, open-minded, mature and balanced than some members of our own profession. To suggest otherwise is mere professional snobbery.

(b) Secondly, I do not understand the relevance or appropriateness of Dr Azuonye's references to the Draft Code of Practice[1]. We all know what heated discussions and disagreements this has caused among psychiatrists, and how unsatisfactory a document many psychiatrists consider it to be. It is quite wrong of Dr Azuonye to use it to attempt to make any point here. It seems to me that the Draft Code of Practice is developing similarities to the Bible: it is long, it is open to a number of different interpretations and it can be used to prove or disprove any argument one cares to put. It really is becoming a hoary chestnut dragged out in some cases to make extremely reactionary points. A certain paranoid feeling of "us against them" has unfortunately developed in some psychiatric circles.

(c) Thirdly, Dr Azuonye is insulting and unfair to Approved Social Workers, who are said to "walk away, without any responsibility", "bear(s) no responsibility", and have "no further duty". The vast majority of Approved Social Workers I have met are thoughtful, conscientious, reflective, and careful. They often spend a great deal of time with the patient concerned (normally very much more time than the GP, and sometimes more time than the psychiatrist). They do not make decisions lightly and go through a great deal of soul-searching and deliberation in making their decisions, particularly where these conflict with the doctor's. They may ask for a second opinion from another Approved Social Worker in cases of real doubt, which is more than