Advances in Psychiatric Treatment (1996), vol.2, pp. 11–16

A managerial perspective on consultant psychiatrists

Lionel Joyce and Rod Perkins

This paper explores the range of expectations of psychiatrists held by those in general management in the health service.

In most Western countries, including the UK, comprehensive mental health services are predominantly funded from State resources. The role of the psychiatrist has changed in the past 20 years and will without doubt change further in the next 20 years. Expectations of psychiatrists have changed and will continue to do so. We take the position that psychiatrists should continue to have the major leadership role in mental health and in so doing must become increasingly responsive to the changes taking place in health care planning and provision.

The major changes in the health system 70 years ago were related to advances in public health medicine. This was followed by a period often referred to as the era of the medical practitioner. During this era, medical practitioners were the cornerstone of the system. In the years following the Second World War, hospitals became more dominant and there were enormous advances in medicine and therapeutics. A little over 20 years ago the managed care movement in the USA began to emerge and this was associated with the early attempts by governments in the western world to contain health costs. The managed care movement has as its dominant feature the health maintenance organisation (HMO). In the past five years in the UK there has been serious consideration given to developing new mechanisms to allocate or ration the health pound. The development of the purchaser/ provider split and within this, the use of the general practitioner as fundholder has been established. There is international interest in the manner in which the UK is seeking to use the market as a mechanism to contain costs, increase quality and improve access. This then is the context in which the expectations we have of psychiatrists are discussed.

Mental health services

Psychiatry has developed alongside these major changes but has not been as linked into them as closely as other specialities, such as surgery. The managed care movement in the US has not embraced psychiatry or mental health services in such a way as to offer those who need these services any security that their needs will be met. The market as it is understood in the commercial context is unlikely to become a dominant feature in mental health purchasing.

Professor Tom McGuire, the Professor of Economics at Boston University has described mental health services in terms of a 'socialist service'. By this he means that they are and will continue to be planned and funded by governments. This provides a particular challenge to the reforming UK health system in which mental health services are treated in a similar manner to other health services by the purchasing agencies. The Trusts which provide mental health services do so on the same basis as those which provide medical and surgical services.

Measuring health care outputs (e.g. number of in-patient days or finished consultant episodes) is a relatively straightforward process. However it is not particularly helpful in evaluating whether resources are wisely applied. Measuring outcomes however is quite different from measuring outputs. If measuring outcomes is fraught with difficulty in medical and surgical areas generally it is particularly so in mental health and psychiatry. Health of the Nation Outcome Scales (HoNOS)

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may eventually prove helpful in this regard (Royal College of Psychiatrists' Research Unit, 1994).

Governments and their economic advisers are interested in two types of efficiency and both apply in the mental health field. Allocative efficiency is about the efficiency of the system or one of its parts in allocating resources to its different components to achieve greatest effect. The question is whether the right amount of resources are being applied to surgery, mental health and so on. Allocative efficiency is also concerned with the allocation of resources within services, for example psychotherapy versus forensic psychiatry. Technical efficiency is different. It is about the efficiency of the system in using resources to best effect.

Both types are important and relevant to those involved in the planning and provision of mental health services. If we are not able to use the market to demonstrate efficiency in both these areas we need a system or a consensus about what we should use. The question is about how we demonstrate that the outcomes, or changes in outcomes, are the same within the sort of mental health system we provide as they might be expected to be in a market driven system. We need systems which demonstrate that the price, quality and results from our work are as competitive as could be provided by another system. In the past 15 years, mental health services in the UK have generated savings from the closure of asylums and from extensive cost-shifting to social security, housing and social services. This has enabled resources to be applied to the provision of a range and variety of community based services. Providers are now arguing that the traditional sources of internal savings are almost exhausted and that future savings must be found from other sources. Because 70% of what we spend in health care is spent on staff, managers are now paying much greater attention to the staff their Trusts employ, what these employees do, and how much they cost.

Mental health teams

Mental health teams take a variety of forms and are required to perform a range of functions. However, in the UK, all are predominantly led by specialist psychiatrists. Other professionals in these teams include nurses, occupational therapists, psychologists, social workers (employed by the local authority) and medical practitioners without specialist status. Historically, cost has not been taken into account when determining who should be members of mental health teams. The decision has been dominated by professional considerations. Traditional employees of the health system have been the members of the teams. Those outside traditional employee roles have been excluded. In this respect NHS Trusts have not normally considered the potential role of the general practitioner as a member of the team. This has been given new emphasis by the work of Kendrick and colleagues (Kendrick *et al*, 1991; Kendrick *et al*, 1994).

Questions are raised by some in management about the extent to which part of the traditional role of the nurse could be undertaken by a practitioner with a lesser training. Nursing assistants and auxiliary nurses could be trained to take new roles. At the same time the role of the 'masters' level nurse is also being explored. An analysis of a trust's core business could lead to the view that the voluntary sector should be encouraged to function across a broader base. In New Zealand much wider use is made of the voluntary agencies in the whole area of social care than in the UK.

Rehabilitation through befriending and work development programmes does not need to be provided by Trusts. Thinking in these terms raises questions about the extent to which psychiatrists need to be involved in all aspects of what has traditionally been accepted as 'consultant psychiatrist work'. Psychologists whose training is extensive can work effectively in some roles in which psychiatrists still function, for example psychotherapy. Increasingly managers and their advisers will be examining the cost of the different professionals and taking this into account when designing teams and delivery structures.

Defining priorities

The work of psychiatrists and the work of other members of the mental health team is of course related. Psychiatrists do, and should continue to, take the leadership role in defining priorities. This is because of their knowledge and appreciation of the medical as well as the behavioural aspects of mental illness, learning disability and distress. The patients/clients with the greatest needs must continue to receive the highest priority for the mental health pound. Exactly which groups come into this category will largely be determined by teams with psychiatrists in the leadership role. Within a resource–constrained environment, psychiatrists will continue to concentrate on the major illnesses and only those aspects of the major illnesses for which direct medical intervention is required. Psychiatric services will continue to move away from accepting responsibility for providing shelter and sustenance. Hospitalisation will be short for most patients with psychiatric

https://doi.org/10.1192/apt.2.1.11 Published online by Cambridge University Press

illnesses and their stays will be characterised by a totally therapeutic experience with little of the social and occupational components involved. Other agencies or elements of the system will increasingly seek to take responsibility for these aspects of rehabilitation. This will pose a particular challenge for psychiatrists as they take a leadership role in programme design which will continue to seek to provide continuity of care for those in greatest need.

Charles Handy, a teacher and writer in the field of organisational development, in studying how work can be performed most effectively and efficiently, has described the 0.5 x 2 x 3 phenomenon (Handy, 1994). This hypothesis holds that in many industrial situations where work practice is modernised, half as many staff as previously were required to do a job will perform twice as much work but receive three times the rate of pay they previously earned. This outcome has been achieved in manufacturing businesses and has had some success in the financial services sector. Experienced captains of industry who get involved as directors of Trusts will often become frustrated that the health sector does not behave according to the Handy hypothesis. Nevertheless, psychiatrists in their positions of leadership will be expected to demonstrate that they are using optimally the health professionals under their leadership. In some cases they do not have either the training or experience to do this and it is incumbent upon them and their employers to meet this training need.

Medicine remains a high status profession. Places in medical schools throughout the UK are keenly sought. Medical specialists enjoy even higher status than their general practitioner colleagues. There are high expectations of all the Royal Colleges. Psychiatrists as both individuals and as members of collectives are seen as the natural leaders in the field of mental health and psychiatry. The community will look to the Royal College of Psychiatrists for an informed opinion. Organisations such as MIND which also enjoy a good reputation within the community will often be consulted, but these organisations do not carry the authority of the College and other informed medical groups. This places psychiatrists in a unique position to exercise leadership across the whole field of mental health. The Royal College of Psychiatrists is regarded as the main source of knowledge and authority on all aspects of mental health. This is so even when the College does not claim this authority in a particular field. Thus psychiatrists and their College have leadership thrust upon them. This applies locally as well as nationally.

While society has the above expectations, within services the specialist psychiatrist is properly looked to by managers and other mental health professionals as the most natural leader. Where there are turf battles it is generally because the psychiatrist is uninterested in the leadership role with all that this implies. Where they are most successful in their leadership role in teams is where they enjoy the respect of others and where they can develop shared values which can in turn lead to good outcomes for patients.

Managers' expectations

Specialities within medicine differ in their ability to influence medicine as a whole. Psychiatrists need to ensure that they provide their services in such a way as to extend their influence into all other specialities (RCPsych and RCP, 1995). In general hospitals this is often achieved through the subspeciality of liaison psychiatry. Those in general psychiatry based in community settings need also to identify the liaison function as a priority especially as it applies to general practitioners (Kendrick *et al*, 1991; Kendrick *et al*, 1994).

Research in psychiatry as well as in the broader fields of mental health and mental illness is usually psychiatrist-led. This is to be expected given the training undertaken both at undergraduate and postgraduate level. It is also to be encouraged. We believe all psychiatrists should be leading and/or undertaking some research and writing. Medical research has not traditionally emphasised the importance of efficiency and cost effectiveness. The expectation is that this will change. In particular outcome research will need to embrace this changing expectation. Managers will continually look to psychiatrists to show leadership in designing studies which show whether services being performed are delivering value for money.

Managers have a variety of expectations of doctors with respect to patient satisfaction. These expectations are influenced by the expectations of patients and are well articulated by the consumer and patient groups which represent these interests (Box 1).

What is sought is a discussion between equals of the options available to manage illnesses. The preferences of the patient have to be balanced against the clinical judgement of the psychiatrist. It is a real test of experience and empathy to negotiate and agree the best way forward. It is a process by which one party with very clear objectives works with another to achieve those

https://doi.org/10.1192/apt.2.1.11 Published online by Cambridge University Press

Box 1 Patients' requirements of psychiatric and mental health services

Autonomy
Help to express their own ideas and feelings and have these taken into account when decisions are made about them
Their psychiatrist to facilitate learning
Their psychiatrist to stimulate independence of thought and action
Acceptance of innovations which change the way clinical practice is delivered
More power over their own treatment
Praise when they achieve and develop on their own
Access to their own psychiatrist

objectives. The psychiatrist will increasingly accept the objectives of their individual patients, (e.g. containment of illness and symptoms, maximising functioning within a personal social context) if these are realistic and then commit to meet them without delay.

The expectations of the families of those suffering from psychiatric illness are changing. Managers will change their expectations of psychiatrists to reflect this. The doctor/patient relationship needs to be re-examined in the light of a changing role and recognition of the family and/or significant other. While the relevance of families (and significant others) is taken into account in diagnosis and treatment planning, the relationship has not received the attention it will demand as families argue for a greater role in decision making about their loved ones. This will result in demands that the NHS reviews its policy towards families and their role in mental health services. Increasingly psychiatrists will need to accommodate and act upon demands from families to understand illnesses and the course of illnesses. It is because families and the loved ones of consumers are at an increased risk of suffering from stress, depression and other physical ailments that those in authority will identify the reasonable demands of families as a priority for attention. Psychiatrists must ensure that they are deeply involved in the development of codes and protocols which will further develop expectations in this area.

The characteristics of a mentally unhealthy community are known to all experienced practitioners of community psychiatry. While psychiatrists as practitioners may have a limited role to play in intervening in such a community, they must work with those in the health and social sectors to define and diagnose problems. Also they must suggest how communities might work with themselves and others to improve community mental health. For example the effect health visitors have on preventing or relieving depression in later life, as a result of their interventions in child abuse, is not well understood. It needs to be. Likewise, voluntary agencies such as the Samaritans, while often having a well understood contribution, have little evaluative support for their programmes. Psychiatrists must help in this area – particularly given the Health of the Nation targets (Secretary of State for Health, 1992).

The psychiatrist – the person

What has been stated so far is that managers have a range of expectations of psychiatrists, many of which are in connection with the role of the psychiatrist as leader. In some instances the role is as a leader of a team while in others it is more diffuse and the relationship is with families and the wider community.

The psychiatrist as a clinician or academic is judged by his peers first and foremost in terms of clinical ability. Historically it is clinical ability alone which has counted. The demand that patients be listened to with empathy and heard with sympathy challenges the traditional balance. Medical schools will increasingly identify communication skills and interpersonal abilities as important ingredients in a medical education. It is no longer enough to be correct in diagnosis and treatment planning. The clinician must be right in the right way and in the right context. They must be right with sensitivity and generosity. Patients can respond very positively to a clinician who can show compassion and caring. Some argue that this is a part of good practice. Patients use positive descriptions of those who deal with them in such ways as to make it clear that they care.

The separation of the purchasing function from the provision function has confused many specialists and their patients alike. The purchasing authority is supposed to define and determine the need for services. It does not limit what a trust may do. It does limit the extent to which it will pay for clinical activity. Patients presenting to psychiatrists in a clinical setting look to their doctor (and sometimes other members of the team) to meet their needs. In this setting, patients do not realise that they are part of an elaborate purchasing/management system let alone that the system is counting them and others for statistical purposes while defining what they are entitled to as consumers.

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Notwithstanding the above, and the desire of all in purchasing and management to allow the clinician to 'get on with the job', psychiatrists need to know how their employing organisation works in order to participate in maintaining its viability. The expectation is that the needs of the unit or service will always be in the back of the mind. This includes management's expectation that the psychiatrist will work to improve efficiency and seek to attract more work which can generate more income. In this context, if there are economies, then it is expected that they will be sought.

With increased specialisation within psychiatry, the interests of one subgroup of patients can come into conflict with the interests of another. It is expected that in service development, the interest of the whole will be taken into account ahead of sectional interest. This is a leadership issue and requires an ability to draw back from the needs of a particular group to focus on the needs of a range of patients or consumers. It is not necessarily in conflict with identifying and acting on an opportunity to exercise political skill. The awareness of psychiatrists pressing home opportunities through the media, political and medical networks, while demonstrating quality has been improved and cost effectiveness is present, can add enormously to the success of a service and therefore its growth and survival.

To some, the expectations managers have of psychiatrists will seem unreasonable. However they have become accustomed to the changing demands from patients and groups representing their interests. There has been unprecedented change in the past 20 years. In this sense there is nothing new. Many of the new expectations are to do with the demands of the new management arrangements and the changing political and power structures. In this particular respect psychiatrists should have very high expectations of their managers and their management structure. Psychiatrists should expect enormous support from their management colleagues.

Managers – who do they represent?

Managers in a health service like the NHS are seldom absolutely clear about who they represent when taking a position such as that taken in this paper. There are at least seven different groups they seek to take into account: Board of the Trust; patients; the community, including patients' families; Secretary of State for Health; Parliament, to whom chief executives are now directly accountable (Secretary of State for Health, 1992); the taxpayer; staff within the service.

This is different from 10–15 years ago when most senior managers would have said they represented patients first, staff second and the tax payers third. The simple answer at present is that top managers are employed by their Trust to serve its needs and aspirations. There are other considerations which result in a need to balance competing claims in order to sustain a single course which will result in the best outcomes for patients.

The Royal College of Psychiatrists is the single most significant body in mental health in the UK and must be the ultimate arbiter of good clinical practice. If the universities are effective they will be at the forefront of thinking about psychiatry. However the Royal College can acknowledge the dynamics of the change process and facilitate the interplay in those dynamics by encouraging changes in the role of the consultant psychiatrist and other members of the mental health team including general practitioners.

The Human Relations School of Management seeks to align the personal goals of individuals with the goals of the organisation (Shortell & Kaluzny, 1995). Schultz *et al* have shown in a study of psychiatrists in four different countries that where there is congruence of goals between psychiatrists and the organisations in which they work, dissatisfaction with inadequate resource levels is less of a stressor on the individual than when there is no congruence between goals (Schultz *et al*, 1993). Put simply, if the psychiatrists working in a Trust support what the Trust is trying to do they will be more accepting of funding difficulties than if they do not support the Trust's direction. Now Trusts receive their funding through contracts established with commissioning agencies. The theory is that if there is no work that the purchaser wishes to purchase, then there will be no funding for that work. This raises the issue of how congruent are the ambitions of psychiatrists with the interests of Trusts and the demands of the purchasing agencies.

In some areas of England, the purchasers are demonstrating through their negotiating positions that they have a serious disinclination to contract certain psychiatric services at existing levels. There is less interest in, and support for psychotherapy in some locations. This challenges a trust and its clinicians involved in these services to work together to realign resources to meet purchaser requirements. It is no longer useful for psychiatrists to assert "patients need this service" or "we are a centre of excellence and should be funded to do this work". Purchasing decisions which result

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in over capacity in some branches of psychiatry or mental health will in the future require a redistribution of the workforce or the divestment of a service. These sorts of considerations should follow rather than precede attempts to educate.

The psychiatric workforce is not evenly distributed across the whole UK. There are places where the ratio of consultant psychiatrists to the population is as low as 1:15 000 while in less popular places it can double or treble. A number of signals have been sent very clearly to the Royal College of Psychiatrists from providers that there is a need for additional consultant psychiatrists. In the event that these signals continue to be ignored, alternative mechanisms for recognising people of sufficient calibre will start to be developed. Providers will have no choice because the loss of significant sections of a trust's business invariably negatively influences the financial viability of the whole organisation.

Specialists should be encouraged to have high expectations of managers. The latter should not expect their specialist workforce to behave as traditional employees and further, the special nature of the relationship that doctors have with patients should not be compromised because of the design of the system or the objectives of its management. The expectations managers have of their psychiatrists should be higher than the expectations managers have of other groups of staff working in the field of mental health and equally, the recognition that goes with the higher expectations should be stated openly.

In the past 12 years there have been four significant reorganisations of the NHS - Sector Management, Unit Management, Trusts and DHA & FHSA mergers. During this time much of the work of psychiatry has gone on uninterrupted. Because those who fund the health system will continue to look for improvements in terms of quality, cost and access, we must continue to expect more significant change in the future. Psychiatrists and the other members of the mental health team will be a part of this future whatever direction it takes. If patient care and welfare is to approach excellence, psychiatrists must work with their managers and encourage them to have the highest possible expectations of this generation of psychiatrists and the next.

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Multiple choice questions

1 Where there is congruence between what a psychiatrist wants to do in his work and what the organisation employing him wants to do:
- a There is greater acceptance of inadequate resource levels
- b Psychiatrists are willing to work longer hours
- c Patient satisfaction is enhanced

2 When economists discuss technical efficiency they are refering to:
- a The technical ability of an organisation to meet consumer needs
- b The efficiency of a business to allocate resources to the most profitable divisions of the business
- c The ability of a system or business to use resources most effectively

3 The authors believe that the voluntary sector should be encouraged by those in leadership in mental health care to:
- a Have an expanded role and function across a broader base
- b Have a reduced role and concentrate on what they currently do
- c Have a reduced role to enable the NHS Trusts to be established on a stronger footing

MCQ answers

1	2	3
a T	a F	a T
b F	b F	b F
c F	c T	c F

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