consultants; one consultant may have a psychodynamic orientation and conduct psychotherapy sessions with his patients, while another consultant adopts a medical model and relies heavily on physical methods of treatment. The treatment a patient receives will depend on which consultant he is allocated to – perhaps related to who is 'on call' at the time of admission, rather than clinical considerations. In some instances, staff concerns may arise about the approach being taken with a patient's treatment, but if this only results in backroom gossip, as opposed to constructive discussion, resolution of the problem is unlikely to occur.

In the examples that I have given, the difficulties were not resolved. The underlying issues involved staff attitudes and values and their relationships. One may conclude that it was too threatening for those involved to examine and confront these issues in the open. This is why hospital pathology becomes perpetuated, and why also, in extreme cases, the nature of problems only becomes apparent following an independent inquiry. However, the primary purpose of a hospital is to provide good patient care and treatment. Cultural factors in the treatment of our patients should be examined properly and worked with in a constructive fashion, not avoided or denied, as often occurs.

If staff pathology is to be worked with, and positive aspects of hospital culture be developed, there has to be adequate communication between the individuals and groups within the hospital; particularly between individuals and groups where conflicts exist. Unfortunately, conflicts stop individuals and groups communicating and the establishment of a culture where there is an expectation that difficulties will be brought into the open can meet with severe resistance. It is also not without risk. Conflicts opened up, but not worked through, may end up having a greater destructive effect than when they were hidden.

The therapeutic community movement, originating with Maxwell Jones in the 1960s, provides in some of its elements a useful model which many hospitals could use to their advantage. Members of professional disciplines who work together should also meet together on a regular weekly basis for 'non-structured meetings' in which clinical, administrative or inter-personal issues can be raised. For the process to be successful, there has to be a clear commitment for regular attendance by all the key members of the team. Inevitably, clinical and administrative agendas will be seen, to some degree, as being related to personal and relationship issues which, as already illustrated, is frequently the case. An independent facilitator can be of much use in the above process. The role of the facilitator is, however, to endeavour to clarify some of the issues under discussion but retain a good degree of independence from the clinical group and not enter a decision-making capacity. The evolution of an effective group can be difficult and stressful, but if successful, combines the ability for individuals and different professions to be able to challenge each other constructively, while having respect for professional and individual boundaries.

The type of model described above can, without doubt, sometimes present itself as a threat to individuals, possibly particularly consultants in their leadership role. However, it is, I would argue, a more hopeful route towards tackling staff pathologies and establishing positive hospital cultures than the methods we more commonly follow of ignoring issues that remain too uncomfortable for us, or compensating for our inactivity and unease by gossiping with sympathetic colleagues.

Erratum

The Second International Conference of the International Association for Forensic Psychotherapy, 26–28 March 1993, *Psychiatric Bulletin*, January 1993, **17**, 24. The title in the main heading should have read International Association for Forensic Psychotherapy.