Correspondence

Accountability and delegation—doctors and administrators

DEAR SIRS

Consultants who, like me, are being drawn into the Griffiths management structure to provide medical advice at service, unit and district level, are in danger of compromising their primary task, that of treating patients.

Our task is defined by the GMC as one of 'offering appropriate and adequate advice and treatment'. In this we are accountable (albeit poorly) in law to our patients only. This preserves confidentiality since we are, unlike *all* other related professions not accountable to, and will not therefore potentially have to report to any third party, such as a line manager or health authority. In this way a confidential relationship can be provided by a state employed doctor.

There is no formal hierarchical relationship between consultants and general managers except in so far as consultants undertake specific management tasks such as clinical budgeting.[1] Although it may seem tempting to manage clinical budgets, since this may lead to greater ease of control over service development, I believe that to accept general management functions delegated by the health authorities is to place consultants in a difficult position, vis-a-vis the health authority and patients, analagous to the social worker who is trying to do case-work or therapy while holding statutory powers and responsibilities.

Is it possible for one person to be both a doctor and manager? Can we both strive to offer each patient the best while also balancing the books? Is the heart surgeon who supports a policy of funding hip replacements rather than heart valves actually working in his own patients' best interests? The conflict of interests between individual treatment and the total service provision should remain *between* doctors and managers, and not be placed within individual clinically active doctors where it will compromise their primary task.

It is possible that government funding for medico-social problems such as child abuse and drug abuse may be channelled through the health service rather than social services, education or the police. In this case there may be an expansion of the services provided by health authorities in which doctors are not responsible for individual patients' treatment. This need not cause alarm and has in fact happened for many years in the area of community medicine.

The health service in general and the conflict of interests between different patient groups clearly needs managing and should be managed by managers whose primary task is to do just that, not to provide patient treatment. Consultants should consult to both patients and management and resist becoming incorporated into the management structure. Medical advice will retain greater potency for generating health if it remains a separate and independent category rather than becoming incorporated as just one more level of management by which the State manages individual lives.

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[1] "Consultants are not accountable to general managers except for any budgets they may hold and for specific and individually agreed management duties. In fact there is no formal relationship between general managers and consultants, and consultants must be able to retain their clinical freedom. There is of course an important working relationship and because of this we have made it clear that in order to be effective general managers must have and retain the confidence of medical colleagues. The Griffiths' report stresses it is essential that clinicians in particular are fully involved in management and we hope that managerial decisions will be made on the basis of constructive discussions.

We would not of course want to discourage consultants from taking on specific management tasks such as heading a sub-division of an administrative unit or assuming responsibility for co-ordinating the introduction of management budgeting. These would normally be part-time duties, and clearly in respect of these functions the consultant involved would be accountable to the health authority through the unit general manager." Sir Donald Acheson, Chief Medical Officer, DHSS, December 1986.

Psychiatric beds

DEAR SIRS

I noted with interest Professor Priest's reply to Dr McGovern's letter 'Hospital beds for Psychiatric Patients' (*Bulletin*, April, 1987, **11**, 131–132). "My letter was well intentioned, but not necessarily to assist psychiatric planners to 'obtain more resources'—sometimes to help them avoid losing what they have at present". This is exactly the situation we in the Dudley Psychiatric Division are in. As a result of a most confusing document, the *Government Response to the Second Report from the Social Services Committee 1984–85 Session, Community Care* Cmnd 9674, our planned psychiatric unit will have only two thirds of the acute general psychiatric beds that the existing guidelines recommend. This is because the West Midland Regional Health Authority (on, they say, the advice of the DHSS) have replaced the bed norm of 0.35 acute general psychiatric beds per 1000 *total* population by 0.35 bed per 1000 population in the age range 15–65 years. As the 15–65 year age group represents two thirds of the total population in Dudley, our bed state is reduced by one third, (i.e. from 112 beds to 72 beds). Our protestations that the figure 0.35 cannot be used for the 15–65 year population is met by the response that we should not interpret bed norms too rigidly.

The (Community Care) document also suggests that the assessment beds for the elderly are to be provided from within the acute general psychiatric beds, (The Hospital Advisory Services' *Rising Tide* makes it quite clear that assessment beds for the elderly are in addition to the acute general psychiatric beds). In Dudley, using the bed norm of one bed per 1000 population over 65 years, this would mean that we should set aside up to 47 beds out of our total of 72 beds. It is difficult to see how we could provide a service for our 319,000 catchment area population with the remaining 25 beds!

The Old Age section of the Royal College of Psychiatrists is making strong representation to the Department of Health about the situation. I feel that general psychiatrists who are involved in the planning process should be aware of what is happening in our District.

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When Approved Social Workers refuse to make applications for admission

DEAR SIRS

Lives there the Psychiatrist
with practice so pacific
who yet hath not fought
verbal wars so terrific
with approved social worker
whose ken's so myopic
he seeth not the madness
for the insanity so horrific...

It would surprise me to hear of a doctor, regularly involved in the admission of patients under the provisions of various Sections of the Mental Health Act,[1] who has not, on at least one occasion, had the experience of an Approved Social Worker who, regardless of medical recommendations, refuses to make the application for admission.

Most doctors find this annoying and frustrating, to put it mildly, especially when their best judgement tells them that the patient genuinely needs to be in hospital, and that there is a risk of the patient harming himself or others.

There are various reasons why the refusal to make an application causes doctors so much difficulty, First, it is perceived as a challenge to medical authority by people who have no training in the diagnosis and treatment of mental disorders. Whatever reason an Approved Social Worker may present for refusing to make an application, it should not be that he or she disagrees with the diagnosis made by the doctors. Secondly, it appears that the Approved Social Worker bears no responsibility for the consequences of his/her decision not to make an application for admission, apart from informing the doctors (verbally) and the relatives (in writing) of the reasons for the decision. This is stated very clearly in paragraph 1.17.8 of the Draft Code of Practice[2] (with reference to just such situations): 'In these circumstances, there is no further duty on the Approved Social Worker, and he is not obliged to provide the relevant Forms..."

What makes it all so unsatisfactory is that an Approved Social Worker can come into the situation, prevent an admission recommended by the doctors, and walk away, without any responsibility for the consequences of the decision, and without the obligation to provide an alternative to the admission recommended. In the case of patients already in hospital, the refusal to make an application often leaves the doctors and nurses with a very disturbed patient on whom treatment can only be enforced under Common Law until the situation with respect to detention under the Act is rectified.

To be completely fair, there are many instances where doctors feel that a patient should be detained under the Act, the Approved Social Worker has thought otherwise, and the patient has gone on to be treated successfully informally. But in my experience, it has been *more the rule than the exception* that the Approved Social Worker who refuses to make an application has had to be recalled later to do so; and has then gone on to sign the forms.

I believe that the following recommendations will receive the approval of all those doctors who are regularly involved in the compulsory admission and treatment of patients:
(a) Part of paragraph 1.16.5 of the Draft Code of Practice states that "the ASW need not question the doctor's indication that mental disorder is present...". This should be recast to state that the ASW should not question the doctor's diagnosis, as the ASW *does not* have the experience or the legal right to make medical diagnoses. (b) It is not right that the ASW should have the authority to block an admission, but have no responsibility for the outcome of his action. Paragraphs 1.17.7–9 of the Draft Code of Practice should therefore be rephrased to specify that the ASW who refuses to make an application *is obliged to provide an alternative for the patient, and is to be held to account* if the patient or other people should come to any harm as a result of the refusal to make the application for admission.

An Approved Social Worker was once heard to say: "The doctors go in and say their bit; then *we* move in and make the final decision..."

Surely, such power must go with at least some responsibility?

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REFERENCES

[1]Mental Health Act 1983. London: HMSO.
[2]Mental Health Act 1983: Section 118—Draft Code of Practice. London: DHSS.