Most staff regard such groups as worthwhile and the work satisfaction for nurses is increased. They have a legitimate sociotherapeutic task to counterbalance the need to observe a disturbed patient or to ensure compliance with medication. Adequate supervision is nevertheless vital. A general psychiatrist with an interest in psychotherapy is perhaps best placed to provide this, or another experienced health professional. A psychotherapist may be helpful if a staff problem is insoluble, or if an inexplicable ward crisis occurs. Occupational therapists and social workers are particularly valuable as they may have had training in descriptive psychiatry as well as in case work methods.

We now intend to evaluate the clinical and cost-effectiveness of these groups but in general regard them as beneficial to patients and within 'good practice' of general psychiatry. A feature of working with groups on an admission ward is the constant need for flexibility of clinical style, a readiness to review management goals daily, the ability to discourage some patients from attending while allowing others to leave. The general psychiatrist who works on an acute admission ward which uses large and small groups may need to be a 'Jack of all trades' and also may be advantaged to be a 'master of none'; the optimum approach to general psychiatry includes an ability to move comfortably between different explanatory models and a too rigid interpretation of one could therefore be a disadvantage.

References

DEAN, C. & GADD, E. M. (1990) Home treatment for acute psychiatric illness. *British Medical Journal*, **301**, 1021–1023.

DEPARTMENT OF HEALTH (1975) *Better Service for the Mentally Ill*. HMSO.

ENGEL, G. L. (1980) The clinical application of the biopsychosocial model. *American Journal of Psychiatry*, **137**, 535–544.

HIRSCH, S. R. (1988) *Psychiatric Beds and Resources: factors influencing bed use and service planning*. London: Gaskell (Royal College of Psychiatrists).

WALTON, H. J. (ed.) (1971) *Small Group Psychotherapy*. London: Penguin Books.

WATSON, J. & BOURAS, N. (1988) *Recent Advances in Clinical Psychiatry*. Vol. 6. (ed. K. Granville-Grossman). Edinburgh: Churchill Livingstone.

YALOM, I. D. (1983) *Inpatient Group Psychotherapy*. New York: Basic Books.

Psychiatric Bulletin (1991), **15**, 686–688

People and places

Chelmsford and its aftermath

JOHN ELLARD*

*John Ellard is Chairman of the general psychiatric practice at the Northside Clinic, Sydney, Chairman of the Board of Practice Standards and Chairman of the Clinical Practice Advisory Committee of the Royal Australian and New Zealand College of Psychiatrists and Chariman of the Medical Committee constituted under the Poisons Act of 1966. He is Editor of *Modern Medicine of Australia* and a member of the New South Wales Psychologists Registration Board. He is also Consultant in Psychiatry to the Health Insurance Commission.

In the past he has been Chairman of the Board of Accreditation of the Royal Australian and New Zealand College of Psychiatrists and a Censor of that College for many years. He was Senior Psychiatrist at the Royal North Shore Hospital and Senior Consultant in Psychiatry to the Royal Australian Air Force. He was also Chairman of the Law Foundation of New South Wales and a Commissioner of Corrective Services in that State.

He has published a book and many articles on psychiatry and related topics.

He is a Member of the Order of Australia.

In mid-1963, Dr Harry Richard Bailey admitted a patient to Chelmsford, a small private hospital in a north-western suburb of Sydney. Between then and April 1979 he, and subsequently a handful of associates, treated a large number of patients with deep sedation, often combined with ECT. The patients' diagnoses included schizophrenia, bipolar disorder, alcoholism, and drug addiction; nothing suggests that the diagnosis and the treatment had any particular connection. Records exist for some 1,100 patients, 24 of whom died as a consequence of the treatment; 16 of them were under the age of 50. Others suffered brain damage, convulsions, delirium, pneumonia, hallucinations, cardiac irregularities, abscesses, urinary tract infections, fractures, and other complications.

A committee of 12 psychiatric experts later assembled to examine such documents as existed reported that "almost all patients reviewed were in

some threat to life during their treatment because of the inadequacy of medical examination, poor nursing care and documentation, and extremely dangerous use of drugs and ECT".

In addition to the medical complications and dangers of the treatment, major concerns emerged about physical assessments before and during treatment, consent, restraint, haphazard prescribing, and other practices which seriously failed to meet the acceptable standards of the day. Additionally, Dr Bailey was sexually involved with some of his female patients.

By the mid-1970s, there was concern among some of the nursing staff at Chelmsford. In November 1978, another psychiatrist, who was using the hospital and not associated with Dr Bailey, instigated a meeting in which he made it clear that one or the other of them had to go: Dr Bailey went. Dr Bailey's colleagues treated a few patients until April 1979 and then the deep sleep treatment, as it came to be called, ended.

Earlier, in 1978, the Scientologists had received copies of some of the records from Chelmsford and had made them available to the Attorney General and through him to the Minister for Health. In this same year, a nurse had complained to the State Health Department.

The media had been asking questions before that, sometimes because of evidence given at Coroners' enquiries, and sometimes because of information received otherwise. In 1980, a widely watched television public affairs programme exposed the situation in some detail, and thereafter the pressure for a public enquiry grew exponentially. Succeeding governments resisted to no avail, and on 16 August 1988, the State Government announced a Royal Commission.

Evidence was given by 297 witnesses on 288 days, producing 18,821 pages of transcript. In addition, the Royal Commissioner sought information from many institutions and experts, both locally and overseas. I have the Report before me as I write; it occupies 15 volumes, much of it a catalogue of catastrophe. The image of psychiatry was not assisted by the fact that four months later, another Commission of Inquiry was to produce another equally condemnatory report on the standard of care in a public psychiatric ward in Townsville, Queensland.

The questions the community asked were what had happened in Chelmsford, who was at fault, why had it been permitted to go on for so long unimpeded, and what could be done to ensure that there would be no repetition.

The Royal Commissioner was as thorough as the statistics of his enquiries would suggest: no one and no organisation escaped scrutiny. It was not within the terms of his Commission to recommend that criminal charges be laid, but he has referred certain matters to the Director of Public Prosecutions so that this step can be considered.

The various arms of the Health Department, its officers, the coroners, the Royal Australian & New Zealand College of Psychiatrists, the New South Wales Medical Board of the time and its committees – all these persons, institutions, and many more were examined carefully to see where the responsibility lay for so long a delay in taking the action which might well have saved many lives and much suffering. To put a most complex matter very shortly, the substantial blame was attributed to those who had the power to regulate and control medical practice. The College not only had no formal power, but also had had senior legal advice to the effect that to pursue the matter further than it had might well have led to heavy damages being found against it and its members. The College was also advised to refer the complaints and the information it received to the appropriate regulatory body, the Medical Board of New South Wales. Nevertheless, the Commissioner took the view that "in all the circumstances the RANZCP may not have responded to complaints and information it received in an appropriate and proper manner", a proposition with which I cannot disagree.

The Royal Commission has nailed down the facts, but there are still unresolved issues. Many of the surviving patients are seeking damages, and various actions are pending against the medical practitioners concerned and some of those who held office at the time that Chelmsford functioned. All these proceedings are complicated by the circumstance that the matters complained of occurred more than a decade ago and further, that judgments in cases already heard have made it clear that because of the time involved, details of the individual patients' care cannot be used as evidence.

It is therefore impossible to predict what the particular consequences of Chelmsford will be. Only one person quite certainly will be untouched by them: Dr Bailey committed suicide on 8 September 1985. His career is too complex to summarise here – it will suffice to say that he was an intelligent man, completely confident of the correctness of his views, and prepared to go to any length to advance and defend them. Thus, for the 24 deaths which occurred, he signed 17 certificates which were probably false. He was rarely out of the public eye, and both his demeanour and his actions polarised those who came into contact with him. Before Chelmsford came to light, he had earnt much criticism in the profession for the amount of psychosurgery which he had caused to be performed on his recommendation. This came to an end after a general enquiry into psychosurgery in 1978 produced regulations which set down certain safeguards for patients' interests.

I think it simplest to say that he was capable of convincing himself of anything that suited him, and

was a ruthless exploiter of his patients, as his needs moved him.

As might be imagined, all these events – and others, such as recent publicity about sexual relationships between doctors and patients – have done the medical profession's reputation considerable harm. Psychiatry has suffered most, for obvious reasons, and some of the responses that the Royal Australian & New Zealand College of Psychiatrists has made may be of interest.

Firstly, and importantly – since it is quite apparent that there have been serious departures from proper professional standards – the College has not fallen into the error of trying to persuade itself and others that there is really nothing to worry about. When the regulatory bodies began at last to take firm action – substantially because of the formation of the Complaints Unit of the New South Wales Health Department in 1984 – the College assisted in those actions and cooperated fully with the Royal Commission.

Before that, in 1982, the College formed a Clinical Standards Committee with the duty of considering material put before it by investigating bodies, such as coroners and hospital boards. Its responsibility was to inform the College Executive as to whether or not there had been a serious breach of professional standards: in every case, the Executive has transmitted the advice to the enquiring body. This activity is to be distinguished from quality assurance, which is concerned with the errors and imperfections that most psychiatrists manage to avoid most of the time.

In the past year, the College has reformed its structure, in that it has two substantial Boards, one concerned with getting into the College and the other with performance while a Fellow. The first of these is the Fellowships Board, which comprises the Examination Committee, the Committee for Training, and the Committee for Training in Child Psychiatry; their functions are apparent from their names.

The second is the Practice Standards Board, which comprises the Committees for Quality Assurance and for Continuing Medical Education, together with the Ethics Committee and the Clinical Practice Advisory Committee. The last named is the Clinical Standards Committee revised. There are, of course, other structures within the College concerned with special activities and interests, and there are also regional committees (the College is binational), but they are not related to this particular issue.

Not all the changes have been welcomed by all the Fellows. Some see any form of scrutiny or monitoring as a threat to their clinical independence, and others regard cooperating with regulatory authorities as supping with the devil. While one can empathise with their misgivings, the events of the last few decades in Sydney and elsewhere in Australia make it clear that psychiatry can go very badly wrong and that if we do not put our house in order, there are others who would be very pleased to do it for us.

We have also learnt that, in a sense, no news is bad news. That is, if in a large region there are no complaints of reprehensible behaviour, it does not signify that it is not present, but merely that it has not reached the light of day. The more carefully we examine ourselves, the more chance we have of protecting our patients and preserving our own reputation.

Lunchtime lecture

A lunchtime talk entitled 'From Trieste to Tennessee – therapeutic design for acute mental illness' will be given by Peter Barefoot at the Chartered Society of Designers, 29 Bedford Square, London WC1 on 19 November 1991. (Chairman: Dr Peter White). Further details: Nell Chamberlain, Design and Industries Association, c/o 17 Lawn Crescent, Kew Gardens, Surrey TW9 3NR (telephone 081 940 4925).

https://doi.org/10.1192/pb.15.11.686 Published online by Cambridge University Press