TALKING POINT

The future of the Health Advisory Service

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The Hospital Advisory Service visited Normansfield Hospital in 1970 and in 1972. But in 1976 there was a strike at the hospital followed by a major inquiry. Did the HAS fail to diagnose the problem or to give appropriate advice? Would another method of visiting or additional powers for the service help to avoid similar problems in the future?

The Hospital Advisory Service became the Health Advisory Service in 1976 and except in Wales it no longer visits hospitals for the mentally handicapped. Some of these are now visited by the National Development Team. The HAS, which now includes formal visiting to local authority services as well as to hospital services, visits geriatric services, services for the mentally ill, and those for long-stay children. The HAS never had the authority or the resources to prevent scandals in the hospital service or indeed to remedy the defects it found. It has always been an advisory body and responsibility for action lies with the various tiers of authority in the NHS. The HAS reports on Normansfield made it clear that the visiting teams correctly diagnosed the local problems and gave appropriate advice. It is equally clear that much of that advice was not followed. The Normansfield Report[1] shows how difficult it can be for the Health Service, with multiple tiers of authority, to deal with cases where there are personality problems. This is particularly true in psychiatry, where opinions differ about the authority of a consultant and about the hinterland between clinical responsibility and multidisciplinary management.

The frequent scandals in the hospital service, particularly in the long-stay sector, and the known problems in many hospitals visited by the HAS make it unlikely that public opinion or Parliament would agree to a system of visiting being abandoned altogether. On the other hand, some people think that the present system is not sufficiently effective and lacks authority and they would prefer an inspectorate with the ability to enforce advice. The inspectorate could remain independent or become a part of the DHSS, but as well as the aversion of many professional staff to such an innovation I foresee two major defects. Firstly, it automatically sets the visiting inspectors in judgment over those visited and must inevitably alter the relationship. One of the real assets of the HAS as presently organised is that fellow professionals can sit down together to examine common problems. This can educate both sides and when conducted with goodwill lead to a frank discussion of the possible patterns of care, necessary improvements, or new approaches to common tasks. Secondly, an inspectorate implies a standard against which those visited will be judged. In many aspects of the Health Service established standards of this kind are neither available nor appropriate.

Anatomy and physiology

There are two parts of any service which visitors need to consider. There are the physical facilities and known financial allocations—the anatomy of the service. These are relatively easy to assess, and this part of the HAS could be taken over by competent administrators or an inspectorate of some kind. The other part, which is more important, is concerned with the way the staff use the available resources, the way they co-operate, and how they co-ordinate the service—the physiology of the service. An assessment of the way the service works is more difficult and here a multidisciplinary approach is, in my opinion, essential. Nurses, social workers, and administrators now belong to independent professions and would take no more kindly to doctors expressing an opinion on their behalf than vice versa. Multidisciplinary assessment and discussions can provide a much more comprehensive picture of the service under consideration than could any individual profession.

Many of the problems in psychiatric and geriatric hospitals stem from a lack of understanding of a multidisciplinary approach to patient care. Where one profession tries to impose its views on another for whom it has no direct responsibility conflicts and problems are inevitable. Typical examples occur on long-stay wards which doctors may only visit occasionally but nevertheless still insist that they are completely responsible for all aspects of life on the ward. Differences may also occur when social workers insist that the problems of the frail elderly are social and that no medical opinion is required. It is difficult to believe that any visiting, other than on a multidisciplinary basis, would resolve problems of this kind.

Should the HAS be given some authority to ensure that its advice is carried out? This suggestion has been made but how could it be enforced, except through the existing administrative machinery? Moreoever, to introduce yet another authority, and in this case one which had power without responsibility, would only add to the existing difficulties and confusion.

There are, however, some ways in which the HAS might become more effective. I think that it would be reasonable to continue a regular visiting service to all the specialties concerned, say, at five-yearly intervals, to provide a nationwide picture of the service for the Secretary of State, DHSS, and others concerned. One of the HAS's chief functions is to report to the Secretary of State, but regular visiting is bound to uncover specific problems which require more urgent action and comment. In these cases short repeat visits, at intervals of say six months, might be made to monitor progress and to bring to the attention of those in authority defects which were not being corrected. It should also be possible to arrange for picked teams to work in hospitals for periods of weeks or months, if necessary, either replacing existing staff who might go to work elsewhere on a temporary basis, or working alongside existing staff. Such a development has been described in one of the annual reports[2] and in my view extending this type of repeat visiting on a larger scale would not be difficult. Either of these approaches might have helped at Normansfield.

In some cases hospitals or parts of hospitals have been pilloried in the local press. Such criticism is destructive and I for one would welcome a more positive approach. In the past the HAS has not attempted to enlist public opinion or use the media as a force for progress. Sometimes there might be advantage in publishing a limited report on a hospital or part of a service, spelling out the major problems so that local opinion could help to encourage the necessary attitudes from which improvements might come. For example, when developing a

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service for the elderly mentally ill the media can help to encourage social attitudes which in turn can make the service more effective.

Changing attitudes

With its present method of working the HAS has tended to look at a particular district and within that district one particular part of the service. There are, however, some known problem areas where this approach may not be appropriate. For example, there are wide variations in the effectiveness of district management teams and at present there seems no system available which will enable a DMT in difficulties to improve its performance. Major problems in co-operation and co-ordination between hospital social work departments and local authority social work departments also occur. The difficulties stem not simply from conflicts within the social work service but often from the way social workers in hospitals are used.

Another area where there are major problems in many parts of the country is in the care of the elderly mentally ill, particularly the elderly demented patients. In my experience, the problems here are not just those of facilities but often of attitudes. Many difficulties occur in the interaction between geriatric departments, psychiatric departments, the rest of the general hospital, the local authority social work services, and the general practitioner. Improvements in services for these patients will often improve the services for many other patients not apparently concerned.

Criticis of the HAS are commonly those in positions of authority, from the DHSS downwards. But if the HAS is to be a success in the future it must have full support from the DHSS, the regional and other authorities, local authorities and staff. The service has been visiting the underprivileged part of the hospital service and is it surprising if the more privileged acute services have sometimes felt threatened by the additional attention and extra resources diverted to mental illness and geriatric care? It has been said that the HAS is prejudiced towards the long-stay services. I would like to suggest, however, that if it did not show obvious prejudice it was failing in one of its tasks, which was to help those services to catch up with others more privileged. Would I be unrealistically optimistic to forecast that the time might come when there have been such improvements in the service offered to the mentally ill and geriatric patients that there will be a need to visit other services to give them their opportunity to catch up in their turn? I hope that I am not.

References

[1] *Report of the Committee of Inquiry into Normansfield Hospital.* London, DHSS, 1978.
[2] DHSS, *Annual Report of the Hospital Advisory Service*, 1971.

GMC Disciplinary Committee: Erasure for procuring abortions

In March 1978 Dr Madhusudan Harishchandra Shivadikar was convicted at Leicester Crown Court on two charges of unlawfully using an instrument to procure a miscarriage. He was sentenced to 18 months' imprisonment. He had appealed against the convictions and the sentence but the Court of Appeal had decided that there had been no error at the trial and did not reduce the sentence.

Last month Dr Shivadikar appeared before the GMC's Disciplinary Committee. In the first case he had told a woman who attended his surgery, claiming to be 17 weeks' pregnant and asking for an abortion, that he could help for a fee of £100. She paid him £60 and agreed to pay £40 after the abortion. After giving her two tablets and an injection the doctor, according to the woman's evidence, inserted an instrument inside her. He told her, if she had any trouble, not to go to her own doctor or to hospital. When she became ill with stomach pains Dr Shivadikar examined her again but she had to be admitted to hospital the next day and was seriously ill for several days from a septic abortion.

Dr Shivadikar consistently denied that he he had performed an illegal abortion operation. He maintained that he had told the woman he would give the necessary recommendation for an abortion and gave her a proper gynaecological examination. The other case had occurred several years earlier.

The Disciplinary Committee considered the case in camera and decided that Dr Shivadikar's name should be erased from the Register.

Transferred child psychiatrists

Child psychiatrists who were transferred from local authorities to the NHS in 1974 and were under 65 on 1 April 1974 may have their sessions in community child and adolescent psychiatric services graded as consultant sessions. This improvement was agreed between the Joint Consultants Committee and the DHSS and takes effect retrospectively from 1 April 1978. A review panel will be set up; the closing date for applications for review is 14 June. These doctors will also be able to enter the NHS Superannuation Scheme and purchase added years (HC(79)7). Nearly 100 child psychiatrists may be assimilated under this agreement.

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Proposed amalgamation of the Greenwich Division and the Bexley Division

Notice is hereby given by the Council to all concerned of a proposal to amalgamate the Greenwich Division and the Bexley Division to form one division, to be known as the Greenwich and Bexley Division.

Any member affected by this proposal and objecting thereto is requested to write to the Secretary of the Association by Monday, 14 May.

E GREY-TURNER
Secretary

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Notice is hereby given by the Council to all concerned of a proposal to amalgamate the Manchester Division and the Salford Division to form one division, to be known as the Manchester and Salford Division.

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