Chairman of the psychiatric division

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The role of a chairman of a psychiatric division is complex and demanding. This article looks at some of the problems but does not pose many solutions. It is unfortunate that some of the recent committees of inquiry into psychiatric services do not appear to have been aware of all the problems. Some clarification of the difficulties may be timely.

Long Grove Hospital is a large mental illness hospital with about 1000 patients. The three-man multidisciplinary management team consists of the hospital administrator, the divisional nursing officer, and the chairman of the psychiatric division. The management team has powers to co-opt and, since its formation three years ago, has helped greatly the organisation and co-ordination of services, particularly for the long-stay patients. Good multidisciplinary management can create an environment which allows more freedom for initiative, including the exercise of clinical autonomy.

Chairman’s role

The chairman of a psychiatric division is a clinician who, more than other clinicians, is involved in management. Chairmen of other cogwheel divisions are in a similar position but may not carry as much responsibility for management. The roles of doctors and nurses in a surgical team are much more clearly defined. A chairman of a medical executive committee has problems similar to those of a chairman of a psychiatric division. The chairman is a consultant elected by his colleagues and is therefore a chairman of equals. He has to depend on the support of his consultant colleagues to release him from some clinical duties and enable him to carry out his role as chairman. Therefore his colleagues have to take on more clinical work so that the chairman does not neglect his own patients, for whom he has an individual clinical responsibility. Individual accountability, as a practising clinician or as a chairman of a psychiatric division, is much more onerous than shared accountability as a member of a multidisciplinary team or as a member of an area health authority. One’s sleep is much less likely to be disturbed by committee decisions taken by an area health authority or by a multidisciplinary management team than by decisions taken about an individual patient, or as a cogwheel chairman. This does not seem to have been acknowledged by some of the recent committees of inquiry. Possibly the clinical autonomy of a consultant is a safeguard to the patient’s interests more often than it is a hazard.

The effectiveness of the chairman depends on trust established between him and his consultant colleagues. If there is insufficient trust, or lack of appreciation of the demands of the position, his colleagues are unlikely to give him sufficient time to do the job properly. This would mean that the management team would probably be dominated by the nurse and the administrator, both of whom have the advantage of being heads of hierarchically organised management structures and able to delegate to subordinates. The consultant member—like the consultant member of a district management team—has to try to present, often at short notice, a view which he considers his colleagues will support. If the issue is important and if he has not represen-

ted a view acceptable to his colleagues he may have to resign. It is not easy to obtain unanimity among eight or 10 consultants, all of whom have clinical autonomy, so that the medical viewpoint may take time to emerge and may be a compromise—the best that can be worked. Without an atmosphere of confidence and goodwill the medical view may not be formulated and may go by default.

Despite these problems, doctors who take a close interest in the management of a large psychiatric hospital are appreciated by their medical, nursing, and administrative colleagues, and the service to patients is improved. One of the consultants giving evidence to the Committee of Inquiry at St Augustine’s Hospital, Canterbury, is quoted as having said: “The big problem is that the medical executive committee [the equivalent of a cogwheel psychiatric division] has got no teeth. It makes recommendations, they are muted, and that is, nothing happens.” This statement highlights some of the difficulties which may face cogwheel divisions, which are medical advisory bodies dealing with policy, but are committees on which nursing, administrative, and other disciplines should be represented in a non-voting capacity. The non-voting position of nursing and administrative staff is a protection to them, as, outnumbered by doctors, they could not be expected to implement a policy with which they disagreed and for which they would be accountable. The role of the other disciplines in the psychiatric division must be advisory, but it is very important. Any cogwheel division that formulates a policy contrary to the views of senior nursing or administrative staff is likely to find itself in difficulty.

Psychiatric decision-making

Decision-making in psychiatric divisions should be by consensus, and a vote should rarely be desirable or necessary. The concept of consensus is complex and is often inadequately understood, despite considerable effort by the Brunel Institute of Organisation and Social Studies to clarify the issues. In paper eight of the Working Papers on the Reorganisation of the National Health Service they state: “the concept of consensus is used in three different ways in the reorganised NHS: first, as in ‘the sense of the meeting,’ for example, in a medical staff meeting; second, as in sufficient consent or support among a group of subordinates; and third, as in consensus with veto power within regional teams of officers, area teams of officers, and district management teams, in which consensus is equivalent to unanimous agreement.” They go on to say: “failure to distinguish explicitly between these three different meanings . . . can lead to serious confusion.”

In the context of decision-making within a psychiatric division or other cogwheel division we need not concern ourselves with the second of the three different concepts of consensus. Although the Brunel workers suggest that in a medical staff meeting consensus refers to “the sense of the meeting,” this is a gross over-simplification and is often not the case when difficult decisions have to be made over controversial matters about which consultants feel strongly. It is then that consultant autonomy can dominate the meeting and prevent a decision being made if it is against the wish of one particular consultant. The difficulties in running an organisation on the basis of a majority vote are well known in management circles. A dissatisfied and outvoted minority may not wholeheartedly support a decision and may be tempted to divagate that it voted against it. Indeed, it may go further and do its best to wreck it.

In the divisional context the term “consensus” often means a consensus with veto power which is “equivalent to unanimous

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agreement.” The division is an advisory body and has little power to enforce a majority vote taken against the opposition of one or more consultants or a vote taken in the absence of a dissenting consultant. Members of a division may become frustrated and they may tend to “opt out,” or take less time than they ought in formulating policies. They may become annoyed that the division is unable to implement their wishes, an annoyance which is understandable but which the chairman can often do little to dispel. The chairman may lose the confidence of frustrated colleagues, and DMTs and area health authorities may not realise how little power he may have to influence divisional policy. A farsighted administration will provide the chairman with backup services without which the role would be almost impossible. Some administrations are not farsighted.

Incentives

There may thus be little job satisfaction for the chairman of a cogwheel division, particularly one in a sometimes neglected specialty such as psychiatry. Psychiatry is in some respects “a different technology” and this may not be recognised. There is no financial incentive for a chairman and it is difficult to see how such financial incentive could be given: as the chairman is elected by his colleagues, he has no security of tenure, and, in most cases, is elected for a limited period. Any financial incentive would be discontinued when the chairman retired and he would suffer a loss in earnings. He must retain his skills and undertake clinical work so that he can return to full clinical duties when he ceases being chairman.

When a committee of inquiry sitting in private recommends the resignation of a chairman of a division and the unpublished report is leaked to the national press a career may be ruined. Yet the report is made by a committee of inquiry which cannot be expected to understand all the managerial problems of running a large psychiatric hospital. There is no court of appeal. Consultants may be excused if they think twice before accepting a position as chairman of a psychiatric division—a position that is, in some ways, one of “responsibility without power.”

Frequently colleagues feel ambivalence to their chairman. On the one hand, there is a fear that he may become autocratic, a re-incarnation of the physician superintendent, wielding his power through the multidisciplinary team. On the other hand, there is frustration and annoyance when the division is unable to formulate and implement clear policies. The danger is that consultants will withdraw from medical politics at the local level and that the medical power vacuum will be filled by the nurses and administrators, whose hierarchical organisational structure gives them a considerable advantage. Service to patients could suffer considerably and morale of the doctors deteriorate further. There is a risk that clinicians will be unwilling to participate in jobs in which they will have no financial incentive, poor job satisfaction, no defence against criticism by outside bodies, and little respect from their own consultant colleagues. The NHS is very dependent on the goodwill of senior medical staff, and consultants work best in an atmosphere that encourages initiative. The problem is how to deal with the abuse of this freedom if it occurs.

Such abuse is not common, nor do “hard cases make just laws.” Effective sanctions cannot often be taken by doctors against other doctors. Anaesthetists can refuse to work with an uncooperative surgeon, but this is hardly relevant in the psychiatric hospital. Here other disciplines are almost inevitably concerned and strong nursing backing for divisional policies can exert considerable pressure on consultants through the nursing members of the multidisciplinary ward teams.

The Challenge

Despite all these problems, chairmanship of a psychiatric division offers a challenge and scope for initiative which is rare in the NHS. The role is central in the organisation of the hospital-based service. The chairman has the opportunity to encourage and co-ordinate the work of his consultant colleagues; to influence decisions of the multidisciplinary management team; and to participate in choosing senior staff, on whom future services will depend. Times of change—such as followed the reorganisation of the NHS—present great opportunities.

The recommendations of the Committee of Inquiry at St Augustine’s Hospital, Canterbury, on the management structure suggested three tiers of multidisciplinary management. The first tier, at ward level, should be attended by six or more members of staff and meetings should be minuted. The second tier, the recommendations continued, should be the clinical area multidisciplinary team to consider policies for the clinical area (roughly one-third of the total hospital catchment area). The third tier should be the hospital management team, which should be composed of six members: the chairman of the equivalent of the psychiatric division; the divisional nursing officer (or delegate); the sector administrator (or delegate); the principal psychologist; the principal social worker; and the head of the occupational therapy department. No guidance was given in the committee’s report on how the hospital management team would reach its decisions. There was no discussion about majority vote or consensus, let alone any guidance about what the word “consensus” should mean in this context. Does one member have a right of veto, or could a proposition put forward jointly by the psychiatric division and the nursing staff be outvoted? It is far from clear whether such a structure, even if it were able to cope with all the extra paper work and administrative work, would be able to control consultant autonomy. Administrative costs would inevitably rise and probable initiative would be sapped rather than encouraged.

Many countries have rightly envied Britain for its National Health Service, and the McKinsey Report* showed how good was the NHS four years ago compared with Health Services in other countries. One of their conclusions was that “Britain . . . has achieved high overall health standards ( . . . well above France, Germany, and the United States) for a comparatively moderate, slowly rising cost.”

Many countries have also been envious of Britain’s mental hospitals. The service provided in these hospitals depends very largely on morale and morale can easily be undermined. It is relatively easy to criticise what is wrong: it is not nearly so easy to put it right.

References

1 Brunel University. Institute of Organisation and Social Studies, Working Papers on the Reorganisation of the National Health Service—Revised October 1972. Health Services Organisation Research Unit, Uxbridge, Brunel University. 1073.


When should a woman aged over 50 leave off taking a low-oestrogen oral contraceptive that is used mainly to control migraine attacks rather than for contraception? Are there any real dangers in continuing the dose for an indefinite period?

One would assume that the low-oestrogen oral contraceptive that the woman is taking is effective; otherwise there would be no point in her continuing with it. I find the response generally to low-oestrogen oral contraceptives is far from beneficial, and, indeed, the reverse may be true and migraine may be made worse. Some people on this pill, and suffering from migraine, have had a cerebrovascular accident. To date, however, they have all been on the normal or high-dosage oestrogen pill. Experience with the low-oestrogen pill is still recent, and one must wait for a year or two before one can say that this is definitely clear. I prefer to try another method of prophylactic treatment in migraine.

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