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LAURENCE MYNORS-WALLIS

Case-loads to workloads – the role of the general adult psychiatrist†

One of the more certain aspects of the uncertain job of being a consultant psychiatrist is that media attention is unlikely to be favourable. Not only are consultants in general being subject to increasing criticism, but psychiatrists in particular are castigated for failing to provide risk-free care in the community. Psychiatrists never seem to be at the centre of heart-warming stories of young lives saved, or of mid-air heroics with coat hangers and gin bottles. It is important, therefore, to focus on what the consultant psychiatrist actually does, and the article by Tyrer *et al* (2001, this issue) provides such an opportunity.

Tyrer and colleagues report that the average annual case-load of a general adult consultant psychiatrist in a North-West London trust is between 200 and 300 patients, of whom two-thirds have severe mental illness. Clearly the psychiatrist cannot be offering much in the way of personal support to such a large number of patients. This, therefore, highlights the question, what is the role they are trying to fulfil?

The task of the consultant in general adult psychiatry is first and foremost to provide medical input and medical leadership to a community mental health team and in-patient service covering a defined sector. Although employing trusts might look for a whole range of other skills (academic, managerial and sub-speciality skills), the main task expected of the consultant is somehow to keep the show on the road. Referrals from primary care must be handled reasonably swiftly, to a suitable standard, ensuring that both patients and referrers are satisfied with the service received. Patients must be discharged as expeditiously as possible from ever pressed in-patient areas to ensure that beds are kept available for emergencies. Requests for emergency assessments must be responded to promptly. Multi-disciplinary working must be in place and operating satisfactorily. One analogy for the role of the consultant psychiatrist is that of air traffic controller – the consultant ensures safe mechanisms are in place, takes responsibility at high-risk times but leaves the long routine work to others.

How should the workload of a consultant psychiatrist be assessed to ensure the clinical tasks can be managed safely and appropriately? Case-load size does not necessarily reflect workload. Similarly, catchment area sizes are too crude to reflect workload, even if adjusted for deprivation. Much depends on aspects of the local culture, including referral habits from primary care, in-patient bed availability, other secondary support services and geography. Attempts have been made to estimate psychiatric workload by breaking down direct patient care activities into new assessments; follow-up of stable patients, follow-up of unstable patients and emergencies (Faulkner & Goldman, 1997). These models need to be further developed to fit local services. At a local and national level there needs to be agreement as to what the essential tasks of the consultant psychiatrist are, and what tasks can be more appropriately fulfilled by team members from other disciplines, or by colleagues in primary care.

The consultant, however, does not simply provide a clinical service, but must have time to be involved adequately within the management and organisational structures of their trust. For all, there is likely to be a minimum of one session a week spent in meetings. For those taking on a management role, this will be considerably more and will need to be reflected in a reduction in clinical duties. In order to meet the demands of continuing professional development (CPD) and re-validation, a minimum of one session a week for professional development should be required. Ideally this should be bleep-free, with a colleague covering emergency duties for that session so that the consultant can attend training, engage in private study, participate in peer review, etc. A survey of old age psychiatrists found only 5% had engaged in private study in the week of the survey (Jolley & Benbow, 1999). The teaching role of the consultant should not just be the teaching of junior doctors, but also assisting with the CPD of non-career consultant grades and in the development of multi-disciplinary training. Teaching, together with audit, will require at least one session a week. If a session is provided for general administration, this would provide for an approximate 60:40 split between direct and indirect day time patient care activities.

In that there is a shortage of consultant psychiatrists, prospective consultants are in a strong position to ensure that jobs for which they apply can be done to an

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adequate standard within the resources provided. Who then is responsible for designing consultant posts that are not so overwhelmed by clinical duties that doctors either cut corners, become overwhelmed by stress (Holloway *et al*, 2000) or retire prematurely (Kendell & Pearce, 1997)? When new posts are approved there should be greater rigour in determining the detail of the workload for the consultant, looking, for example, at past referral patterns, how many new patients will be seen, how many existing patients will need to be followed up and how many in-patients are predicted. The College approves training posts and also new consultant posts, but has no input into existing consultant posts. As revalidation mechanisms come in for doctors, revalidation for consultant posts could ensure that they are appropriate to allow the post-holder to fulfil the demands of the new, modern, NHS.

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Laurence Mynors-Wallis Medical Director, Dorset Healthcare NHS Trust, Alderney, Ringwood Road, Poole, Dorset BH12 4NB

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