"... a somewhat autocratic ... manager would be appointed with significant ... powers, who would ... be able to make major decisions against the advice of the profession. It should be clearly understood that the profession would neither accept nor co-operate with any such arrangement....[3]"

In the event, such opposition has not carried over into the views of individual clinicians, and nor has the apparent threat been fulfilled, as is shown by two recent empirical studies of the impact of the Griffiths changes.[4,5] One of these is specifically related to psychiatrists, while the other is a larger and more general study. But the findings are consonant and can be summarised in the following terms.

Firstly, there is little discernible opposition in principle to the notion of general managers, and no apparent desire to return to the pre-Griffiths system of formalised consensus decision making. Secondly, however, general managers have not turned out to be all-powerful. Consultants still have substantial power to obstruct unwelcome changes, and managers' assumptive worlds are still centred on the notion that doctors should not be challenged. Thirdly, doctors do see advantages for themselves in the new arrangements. They are now clearer than before about which managers are responsible for what, and many discern quicker decision making, greater delegation and better implementation of decisions. Fourthly, and in contrast, these advantages have been at the expense of a perceived reduction in consultation with the medical profession, and some consequential bad decisions about patient care.

The Griffiths changes have, of course, coincided with increasing financial stringency in the Service, and a number of post-1982 changes may more plausibly be attributed to this changing climate than to the Griffiths initiative itself.[6] Among these are much greater awareness by doctors of the cost implications of their work, and much greater power for managers in one specific area: service closures against medical wishes, in order to avoid overspending. So the Griffiths changes have not, as the profession originally feared, produced a massive shift in medical-managerial power relationships.

Paradoxically, however, this makes management education for doctors more important than before, since it is likely that continuing financial restrictions will increase managerial influence, a trend likely to be reinforced by the proposals in *Working for Patients*. What is crucial, therefore, is that managerial and medical concepts of what represents 'good performance' in medicine and health care are as far as possible integrated. In addition, micro-level managerial skills, employed for the patient's benefit, will become increasingly important as the British health care system becomes more fragmented across a multiplicity of agencies and institutions.

Management education, at all levels of the medical profession, would be one vehicle for the achievement of these objectives.

Notes and references

[1]Details of the MBA (Health Services) Programme, and short courses at Leeds and on health authority premises are available from the author at 71–75 Clarendon Road, Leeds LS2 9PL.

[2]HARRISON, S. (1988) *Managing the NHS: Shifting the Frontier?* London: Chapman & Hall, chapter 3.

[3]SOCIAL SERVICES COMMITTEE, First report; *Session 1983–84: Griffiths NHS Management Inquiry Report*, London: House of Commons Paper no. 209, p. 2.

[4]HARRISON, S. & SCHULZ, R. (1989) Impact of the Griffiths Reforms of NHS Management: The views of psychiatrists, *Health Services Management Research*, Vol. 1, no. 3.

[5]—, HUNTER, D. J., MARNOCH, G. & POLLITT, C. J. (1989) General management and medical autonomy in the National Health Service, *Health Services Management Research*, Vol. 2, no. 1.

[6]POLLITT, C. J., HARRISON, S., HUNTER, D. J. & MARNOCH, G. (1988) The reluctant managers: clinicians and budgets in the National Health Service, *Financial Accountability and Management*, Vol. 4, no. 3.

Management training in psychiatric practice

LIONEL JOYCE, Unit General Manager, St Nicholas Hospital, Newcastle upon Tyne

If I take the basic learning need level, then what all psychiatrists need to acquire during the time that they are registrars and senior registrars is a certain hard knowledge and a number of skills. The hard knowledge relates to understanding the organisation in which they work. To understand this they need insights into the different disciplines, not just the experience of referring a patient to a psychologist or talking to a ward nurse, but a real insight into the background of these different disciplines, what their current world view is and what their real aspirations are. They need an insight into industrial relations, an insight into the tenets of personal management and an awareness of the local political scene – by that I mean both local politicians and Health Authority politics (DHSS, Region and District). They also need information about voluntary organisations.

Alongside this is some managerial skills training. There is also a view which is quite inhibiting – that management is what happens between a line manager and his subordinate; this is a myth which must be firmly scotched. A consultant having contact with a clinical nurse specialist, with a ward manager, with a staff nurse, or with a psychologist of the clinical

team, has a management relationship with those people unless he wishes to avoid it. In sitting down with them to discuss a particular patient or a particular service he will inevitably be discussing with that individual, their own view of the patient and of the service and that should automatically open up in his mind questions about their needs and their development. It will raise in his mind questions about how he helps them to perceive the patient or the services in the most appropriate way. That is all that most management is about and should be all that line management is ever about. This could be expressed in managerial terms as follows "to influence the thinking of nursing staff on the ward to . . .". Could this be set as an objective for a senior registrar on an attachment?

The second level of skill that all consultants need to have is much of the previous understanding enlarged and projected into a clearer view of how decisions get made. Decisions in the management arena are influenced by many more factors and each of these factors is often complex. For example, a decision to try and save £10,000 on domestic services and release it into the development of a clinical service will involve the following set of judgements:

(a) Could the domestic services stand it in terms of quality of cleaning. Will the manager and the trade unions and staff within the Domestic Department wear it?
(b) Will the District find out about it and if so, will they try and take the money back to District?
(c) Which clinical service needs development? Which is ready for development? Which service needs and is ready for development and is the most cost effective scheme? Will this scheme improve services to patients or the quality of life for professionals? Which professional discipline will benefit from this investment, i.e. is it an extra nurse, an extra psychologist, an extra doctor? Will this development actually achieve progress for that profession, i.e. it is an innovative post? Does it move the profession in the way we want, for example, giving nurses more more autonomy or making psychologists more service-orientated?
(d) Will this particular service development outrage clinical colleagues who will try and sabotage it, i.e. not more money into that discipline when we need to develop this?
(e) What are the political dimensions of the members of the Health Authority and the Social Services Committee?

It will be seen that in making a very small resource change there are potentially a very large number of vociferous pressure groups brought into play and much of the art of health service management is knowing how to cope simultaneously with all of these different pressures.

This leads on to a specific problem that clinicians have relating to the time frames in which they are required to think. Most clinical work is immediate, with a time frame very often of no more than a month at the outside; sometimes this will extend to six months, rarely beyond. In managerial terms almost no decisions are made that take place within a month and at senior management not many of the important decisions have a time scale of less than two to five years. Many are on a time scale of three to ten years. Management training in psychiatric practice therefore needs to expose these very different perceptions and the consequences of them and to enable doctors to clearly operate in different modes.

The final area of training is the specialist training required by the Unit Medical Representative and that small number of clinicians with a special aptitude and interest in management. These clinicians, who will normally end up as Chairmen of Divisions, HMC, UMRs, Chairmen of Regional Specialty Committees, need to be given the opportunity to think about whole service planning across the District for all developments or across the country for mental health.

As a practitioner I believe in practice rather than theory. The recent experiment in our Unit whereby a senior registrar shadowed me for a week was valuable. Her comment that she left with me was that she was surprised at how like a psychiatrist's job that of a UGM was. I would like to take that experience which enabled a senior registrar to see all of those pressures in play and enlarge on it in a way that would allow senior registrars, in training actually to experience some of the pressures by making decisions directly themselves, and we are trying to work out an experiential learning opportunity that will bring this into being.

As each speaker had been asked to approach the topic from a different perspective, a broad and interesting picture emerged. This generated a lively discussion which Professor Sims, the Dean, opened by asking at which point in training management education should start to take place. Should this be at general or higher professional training level and should its presence be monitored by approval visits? To measure the effectiveness of training should questions on management be included in the Membership Exam? It was suggested by another contributor that as management training was so crucial, successful completion of it might become a prerequisite for consultant appointment, assessed by an exit examination set towards the end of senior registrar training.

Another area of discussion was how management training should best be provided; at a local level, in an experiential manner with skilled and successful consultants as role models or with sympathetic and educationally minded managers; or on specialist management courses for psychiatrists. Both were considered essential and great concern was therefore expressed over the increasing difficulties in obtaining funds for psychiatric trainees to attend formal courses; a surprising development when the 'consultant as manager' is being so widely encouraged.

Statement on abuse and harassment within psychiatric hospitals

Incidents involving sexual harassment of patients in psychiatric hospitals have been brought to the notice of the Public Policy Committee. Sexual abuse and harassment may be seen in the context of more general misuse and exploitation of patients by other patients or members of staff or intruders. These incidents vary from kerb crawling by intruders within hospital grounds to sexual exploitation of weaker or less able patients by those capable of wielding more power. Managers should be responsible for maintaining the safety of hospital grounds from intruders.

Particularly vulnerable are adolescents with psychosis who are in adult wards and the more mentally handicapped patients who are at risk from those who are mildly handicapped. Where there is a clear difference in the amount of power possessed by the two involved, steps must be taken to protect the interests of the weaker ones, especially when there can be no question of valid consent. Difficult issues arise when there is only partial consent or when both parties have formed a strong attachment to each other in conditions of somewhat restricted lives. Such occasions can occur in secure units, in long-term mental handicap hospitals or continuing care wards catering for the elderly mentally infirm.

These problems are best tackled by education. Sexual education and counselling aimed at increasing awareness of self, personal boundaries and the right to make decisions about one's own body are appropriate for younger or mentally handicapped patients. Contraception advice should be available but must always be accompanied by counselling. Training of staff should include appreciation of the social, emotional and sexual needs of patients.

Dr A. GATH
June 1989

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