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correspondence

New Ways of Working

Being told that New Ways of Working is a new way of working is not enlightening (tautologies are true but rarely helpful) but demonstrates the problem – it is whatever you decide it is.

Redefining the role of a psychiatrist is fine but Vize *et al* (*Psychiatric Bulletin*, February 2008, **32**, 44–45) provide another tautology – 'a role that encompasses the full scope of the work in which psychiatrists could be involved'. What people do is whatever is decided they do but this statement does not give a new 'what'.

New Ways of Working arose from a crisis in consultant recruitment, a mismatch between consultant expansion and training numbers (Goldberg, 2008); from perceived necessity, not choice, and as such it is a pragmatic business solution to a particular demand and resource problem, not better patient care. Changing roles is not new and was happening throughout medicine. Let's be honest, not grandiose.

New Ways of Working is now used to legitimise redesign of any sort with services being destroyed for business reasons. Is it person centred or organisation centred? To improve the lives of psychiatrists or patients? Ironically, we will soon overproduce psychiatrists under Modernising Medical Careers while facing an impending crisis of nurse shortage.

Alternative ways of working are essential because solutions to the problems of one person, service, specialty or point in time may not be the solution for others.

Vize *et al* must be clear not only what New Ways of Working is but also what it is not. Otherwise, it becomes whatever people, including primary care trusts and trust managers, decide it is. Everything is good because it is New Ways of Working. However, 'new' is not enough and 'new' is not necessarily good!

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New Ways of Working: fences and cuckoos

There is a clue in the capital letters: New=old, Ways=one way, Working=work avoidance. It is Newspeak.

It did not occur to me when responding to the histrionic outpourings of oppressed general psychiatrists (Jolley, 2002) that their despair would spawn a quasi-religious management sect. I drew attention to practices within other specialties which maintained morale and positive service profiles and suggested that a more equable spread of manpower would reduce the difficulties.

In semi-retirement I have experience of general and old age psychiatry reconfigured to the model commended by Vize *et al* and Kennedy, and questioned by Lelliott (Vize *et al*, 2008; Kennedy, 2008; Lelliott, 2008). Every device is deployed to separate patients and families from consultants: to fragment patterns of care and to divert ('signpost') expectations and responsibilities elsewhere.

This is not the work of thoughtful, caring, clinical innovation which sparked and sustained my enthusiasm, confirming that we are available, with knowledge, skills and wisdom for people wherever they are in need (Jolley, 1976). Community psychiatry, including old age psychiatry, demonstrated professional humanity and superbly efficient use of resources. Let us return to the lessons of the recent past and set aside these ugly new clothes. Those who have been led astray are not to be blamed, but understood and thanked for the challenge they have given us. There is always something to be learned: we can do better. Taking down fences rather than sitting on them or jumping from them might be a good idea.

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LELLIOTT, P. (2008) Time for honest debate and critical friends. Commentary on . . . New Ways of Working. *Psychiatric Bulletin*, **32**, 47–48.

VIZE, C., HUMPHRIES, S., BRANDLING, J., *et al* (2008) New Ways of Working: time to get off the fence. *Psychiatric Bulletin*, **32**, 44–45.

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New Ways of Working: power, responsibility and pounds

We need a debate on New Ways of Working (*Psychiatric Bulletin*, February 2008, **32**, 47–48): good principles are being distorted by a range of conflicting influences – the most powerful is money (Sainsbury Centre for Mental Health, 2003). Doctors are expensive. Financial pressures encourage use of a cheaper member of staff whenever possible: replacing expensive staff with cheaper staff puts us at the cutting edge of New Ways of Working! This distorts team structure and working at all levels. Sometimes it might be appropriate, allowing highly trained staff to focus skills where needed. Alternatively it might deprive patients and families of access to expertise, and lead organisations to push staff to shoulder responsibilities which they feel are beyond their competencies or for which they are not adequately trained or remunerated.

Other pressures involve power and responsibility (General Medical Council, 2006). Undoubtedly there are people/organisations who see New Ways of Working as diminishing doctors' 'power'. Some fear that New Ways of Working diminishes medical responsibility, and leaves other staff carrying levels of responsibility that they are uncomfortable with, or worse, no-one has responsibility. But is power a finite package that gets cut up and doled out? Or can we become, by joining together, a more powerful force to work in the interests of patients and families?

Paradoxically, New Ways of Working stereotypes professionals. Organisations describe what different professionals do

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and how they should be working and, instead of introducing flexibility, enforce rigidity. They lose person-centred holistic care by replacing skilled clinicians with tick-box policies and procedures (Drife, 2006) for people working beyond their competencies.

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Assessment of mental capacity: who *can* do it, or who *should* do it?

I was interested to read about the discrepancy in the number of capacity assessments carried out by doctors on general adult and old age psychiatry wards (Singhal *et al*, *Psychiatric Bulletin*, January 2008, **32**, 17–19). Although the authors gave no explanation, the result could be because in-patients on the general adult wards, who probably lacked capacity, were more likely to be detained under the Mental Health Act and therefore fell outside the Bournewood gap.

This result does however support my belief that doctors on general adult psychiatry wards do not assess their patient's capacity (to consent to treatment) often enough.

I took part in a survey (Hill *et al*, 2006) in which consultant and trainee psychiatrists were asked, 'What are the key elements in the assessment of a patient's capacity?' Over a third of the 95 participants could only identify two or less of the five points in testing decision-making capacity (Department of Health, 2005; Re C, 1994). This suggested an inadequate level of knowledge and I believe that as doctors we could become even more de-skilled, should we rely entirely on our nursing colleagues to fulfil this role in future.

The authors make the point that, 'Appropriately trained mental health nursing staff can undertake this assessment.' I am sure they *can*, but *should* they?

I believe it is appropriate that as prescribing doctors, *we* should be assessing our patient's capacity to consent to the proposed treatment, and not merely delegate these duties to other healthcare professionals. This makes sense from an ethical and medico-legal perspective.

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Re-examination of forensic psychiatry needs a proper examination of alternatives

Turner & Salter's re-examination of the relationship between forensic and general psychiatry was provocative and rehearsed the criticisms from generalists towards their forensic colleagues (*Psychiatric Bulletin*, January 2008, **32**, 2–6). No doubt it is important for forensic psychiatrists to consider external views in reflecting on their own practice. However, I feel it necessary to highlight the fallacy of simply adopting the US system, as was suggested by the authors. Their approach of effectively separating the treatment of offenders with mental disorders from the contribution of psychiatry to the court-room brings with it serious ethical problems which should not be overlooked. One line of thinking, as advanced by Stone (1984), argues that clinicians should not act as expert witnesses as they cannot help but use their therapeutic skills at interview which may induce disclosures used by courts for non-medical purposes. However, this raises the unedifying prospect of participants in the legal process unused to delivering psychiatric treatment being responsible for advising the court on mental health disposals. This does not seem to me in the interests of the justice or the best way to ensure treatment needs are met. An alternative view expressed by Appelbaum (1997) argues that psychiatric testimony falls outside traditional medical practice and therefore is not subject to traditional medical ethics, meaning that psychiatrists need not feel bound by medical ethics when acting as expert witnesses. However, it is difficult to see how a trained psychiatrist would not, unwittingly or otherwise, use their specialist interviewing skills in obtaining evidence from a defendant. For this reason they should be bound, at least in part, by the ethics of their profession.

In my view, the most appropriate approach to be taken in the UK was explained by O'Grady (2002), who incidentally provided the response to Turner & Salter's article (2008). O'Grady argues that forensic psychiatrists should adhere to both justice ethics (truthfulness, respect for autonomy and respect for the human rights of others) as well as medical ethics (beneficence and non-maleficence). This type of theory of 'mixed duties' was approved by the Royal College of Psychiatrists (2004). It encourages forensic psychiatrists to be highly sensitive to the ethical dilemmas inherent in their sub-specialty. I acknowledge the brief nature of Turner & Salter's article, but feel their suggestion that the problems they perceive could be resolved simply by adopting the US practice is overly simplistic and should have been accompanied by a description of the limitations of this approach.

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STONE, A. A. (1984) Ethical boundaries of forensic psychiatry: a view from the ivory tower. *Bulletin of the American Academy of Psychiatry and Law*, **12**, 209–219.

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Does hyoscine need to be 'legally' prescribed?

A recent visit to the Wickham Unit (a low-secure rehabilitation unit) at Blackberry Hill Hospital, Bristol, by the Mental Health Act Commission raised a controversial issue regarding the legal prescribing of medication for individuals who are detained under the Mental Health Act. There was a case of a patient who had consented to treatment and had a Form 38 completed in accordance with Section