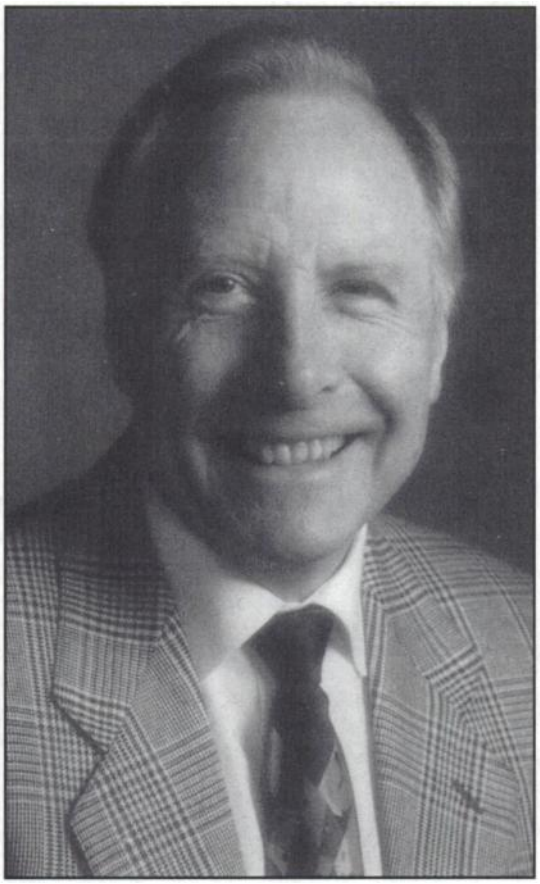
Desmond Kelly

In conversation with David Tait



Desmond Kelly

Desmond Kelly's decision to enter psychiatry was finally settled while dining with the late Dr William Sargant at his club. After National Service he returned to St Thomas' to do his MD and, after six months at the Maudsley Hospital, spent a year at Johns Hopkins, Baltimore on a Nuffield Fellowship. His consultant career began with 10 years at St George's where, in addition to extensive teaching and committee duties, he published over 50 papers and his book *Anxiety and Emotions*. He then became Medical Director at Roehampton Priory Hospital.

He established links between the Priory and Charing Cross, University College London and St George's. These links with medical schools culminated in accreditation by the Royal College of Psychiatrists. In 1992 he became a Visiting Professor at University College London. Dr Kelly's involvement with issues in addition to his clinical and management responsibilities have included the College's 'Defeat Depression' campaign. He is currently Patron of 'The National Depression Campaign', its successor.

It is his involvement in independent practice, however, which sets him apart. His leadership grew from Medical Directorship of a single hospital to becoming Group Medical Director of a score of hospitals throughout the UK, with a seven-fold increase in bed provision and a steady development of specialist services. During this time he became a Board Member of the parent company and was also Chairman of the group for five years.

Desmond Kelly retired this year.

When I studied your curriculum vitae it illustrated a traditional, but very distinguished, clinical and academic career in London teaching hospitals. The move to the independent sector, as Medical Director of Roehampton Priory Hospital in 1979, must have been an extraordinary leap into the dark.

I had spent 10 exciting years at St George's, but I wasn't sure what the next 10 years might hold. The private sector of psychiatry in Britain at that time was having problems, however, so I did have one condition: that I should be Medical Director. If the ship hit the rocks I wanted to be on the bridge.

When I arrived I set myself the challenge of making the Priory one of the best hospitals in the country, to create an ambience of excellence. On the outside it looked like a palace but the inside left a great deal to be desired. The consultant staffing needed to be built up and there was no teaching tradition. I had been Vice Chairman of

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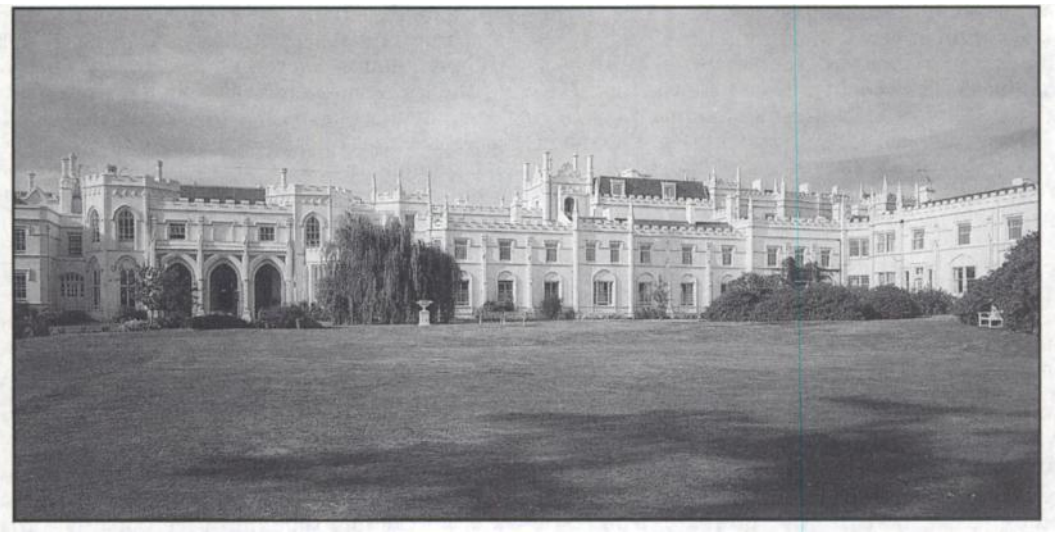

Roehampton Priory Hospital

the Medical Advisory Committee at St George's and trying to get things changed in the National Health Service (NHS) was a daunting task. But in a small hospital you can experiment; if it works you stick with it, if it doesn't you do something else.

What I hadn't realised was that negotiations were under way with an American company to take over the Priory. In a way it was a relief because they had the experience of running 20 hospitals in America as well as the financial resources, which were so sorely needed. I also discovered that the board had not taken any account of the contracts of people who had been at the Priory for many years and I led a revolt of the staff against the board to ensure that these contracts would be honoured. That was my closest piece of brinkmanship, because I wanted their experience of running 20 hospitals and their financial backing, but there was a risk that they would be frightened off, thinking there was a big troublemaker at Roehampton.

They sent over a very talented first chairman of what was later to become the new company and I was determined that the Roehampton Priory would become the flagship of the expansion which they envisaged taking place across Britain. So there were some sleepless nights in the early days but I'm glad I went for the opportunity when it presented itself.

In what ways does your day to day clinical practice here differ from your NHS experience?

We have much more face to face contact with our patients; consultants see their in-patients up to five times a week. This is much more than I spent with individual patients at St George's and so the emphasis is different. The 'patient clientele' are different in that many of them are extremely keen to get better and they are prepared to work at their recovery in a way that some folk in the NHS are less enthusiastic about. Consultants are the leaders of the multi-disciplinary teams, which have evolved over the years and we try to make the therapeutic milieu as active as possible. Patients respond by being more active too, for example in the use of logbooks, which were pioneered in the Eating Disorders Unit, but which are now used throughout the hospital. We also have an outstanding unit for treating patients with alcohol and substance misuse problems.

I have also tried to bring together a group of consultants who share a common philosophy. All psychiatric hospitals have frictions and tensions within them, and to have a body of consultants who support similar goals is crucial. My task as Medical Director was to act as a catalyst to enable them to produce their best professional expertise. I believe this has contributed greatly to the success of the hospital because if the consultants aren't up to scratch then things will fall apart.

The other thing which struck me early on was that at St George's I never felt responsible for people's jobs. When I came here, I quickly learnt that if the hospital got into financial difficulties people went on short-time or lost their jobs, and that became something of an obsession. So the burden was not only responsibility for clinical care but also that by making the hospital successful people would have secure employment.

Do you think the patient also experiences a difference between the two sectors?

We do of course treat many patients from the NHS, as extra-contractual referrals; including

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contracts with Camberwell and Riverside in the past. I remember a patient from Camberwell who, when asked by the Mental Health Act Commissioners whether he minded being here, he said "Mind? Do you think I'm crazy?"

We can accept very ill patients, but manage them without locked doors. Almost all have single rooms. They benefit from specialised treatments not always available on the NHS, such as for eating disorders. The Therapy Department has a whole range of experts be they on yoga, exercise, crafts, cognitive–behavioural therapy or assertiveness training. I personally use a lot of audio tapes as structured counselling for my patients. Not only can they learn these skills when they are here, but they take the tapes, books and other material away with them after they leave so that the process continues.

We are not a forensic unit, so people who set fires, murder or rape are not people whom we could accept here in the ordinary course of events. We know that if we had too many NHS patients that this would have a negative impact. The number of NHS patients is steadily falling at present, it is important to keep the overall mix correct.

Is your management role restricted to medical issues or is it more like the enlightened physician superintendent of many years ago?

I think that is a valid comparison. When I first came I was concerned to protect the interests of staff then in post at the time of the take-over. At one time I was likened to being a headmaster and took that very seriously. This is of course balanced by the fact that the other 10 consultants here are independent contractors and have clinical freedom to practise in the way they wish.

The good thing about our clinical meetings is that we can monitor one another's treatment programmes, and in this way we learn a great deal from each other in a multi-disciplinary setting. I am a Type A personality and see the job more in terms of excitement than pressure, motivating others, giving them the opportunity to give of their very best.

Over the last 18 years you have seen bed numbers in the Priory Group increase seven-fold. How do you see the NHS reforms over recent years with the attempt to import practices from the private sector into a public service?

I realised from the very beginning that financial accountability was essential. This was the main message I brought back from a year's research at Johns Hopkins, Baltimore; good management saves money and bad management loses money. But the company must also invest its profits into the clinical field so that its reputation for treatment grows. These aims can seem to go in opposite directions, for example at one time our teaching and research efforts were at risk, but the unanimous voice of all the Medical Directors in the group prevented that being undermined. Some doctors in today's NHS may feel that they have lost that influence.

I consult in a general practice once a month and take a medical student with me. The medical students from Royal Free and University College Medical School voted the Roehampton Priory the best psychiatric teaching firm in 1997/98. The hospital is clearly an appropriate setting to teach general practitioner trainees, but many of these young doctors are worried about changes to general practice. The psychiatric senior house officers who come to us on rotation express their concerns about some inner city consultant posts, which appear unattractive. This contrasts to the time when I took up medicine when the NHS was one of the best ideas I had come across, it really was an exciting time and I feel fortunate that I was in the NHS in what I think was a golden era. I think that community care has failed, the Government have said so, and some of the inner city consultant posts are enormously unattractive. Many of the teams which pioneered community care and wrote the classical papers dispersed after a few years. I don't believe that running an inner city catchment area from the age of 35 to 65 is going to be possible with too few beds, the strain is simply too great and people will vote with their feet and do something else. Some will feel that private practice is a legitimate thing to do although there are many who are strongly opposed. But I think it enriches the nation, it has given us a different kind of model and one needs this to see how to improve one's own service.

I have other reservations about the direction of psychiatry at present. We do not emphasise enough the fact of psychiatry, and medicine, being an art, we do not embrace the diversity of personalities and range of opportunities sufficiently and we must carefully choose people who are healers, that is those with empathy, genuineness and warmth. We must avoid the cook-book approach to medicine with too much emphasis on evidence-based protocols. I think Project 2000 has led nursing up a blind alley and if we cannot recruit nurses and doctors there will be little future for NHS psychiatry. I am also very clear that the private sector can build hospitals much more quickly and cheaply than the NHS capital finance system.

Do the NHS and the independent sector try to learn from each other?

As doctors we do but there seems to be little opportunity for managers. We meet with our visiting consultants and go to College meetings.

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Dr John Henderson (then Medical Director of St Andrew's Hospital, Northampton) and I felt passionately that the significant numbers of consultants in private practice should have a voice in the College, and this led to the establishment of a Special Interest Group in Independent Practice. It is crucial to stress that it is the Royal College of Psychiatrists, not the Royal College of NHS Psychiatrists to which we belong.

How do you see the future of psychiatry, and of private practice within it?

I see managed care as a real threat to our mode of practice. For example, some insurance companies in America only allow a psychiatrist three days or less to stabilise a patient in hospital. This is completely unrealistic. The trend which I most welcome, and which is inevitable, is demonstrating that what we do produces clinical improvement. Whether it is health authorities, insurance companies or people themselves paying for treatment, they are going to demand outcome studies on the results of treatments.

I have a son in psychiatry in the NHS so I have a particular interest in its success. But for a consultant who is established in an NHS post, private practice can be both very challenging and can offer a contrasting model to enrich that consultant's NHS work.

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