WHAT IS THE DOCTOR'S ROLE?

The Campaign for the Mentally Handicapped (CMH) has just issued its Enquiry Paper No. 8: 'Who's Consulted? The Future role of the Medical Specialist in Mental Handicap', which raises once again some questions which face the NHS as a whole. Can hospitals be successfully run by multiple committees only? Does a patient get the best treatment from a multidisciplinary team operating by consensus without a formal leader? How can both patients and the community be best served within the constraints of available money and available trained personnel?

'Our prime concern', writes Mr Alan Tyne, the author of the paper, 'is to develop appropriate services for mentally handicapped people, not to protect the job opportunities and working conditions of particular professional groups', and 'The issues debated by the Royal College have become increasingly concerned with the power, prestige and career prospects of their own members, and less concerned with pinning down and clarifying the unique contributions which consultants are able to make. In this, the Royal College's debates have departed considerably from those heard commonly around the wards and units of mental handicap hospitals, and among a great many of their colleagues going about their everyday work.' He means, as we all know, that some nurses, social workers, psychologists, sociologists, etc, challenge the doctor's position as an authority. They don't find it decreed by the Law; they don't like it deriving from the tradition, ethics and training of the medical profession (like the 'white man's burden' of imperial times), and they can't stand the fact that society rates a doctor higher than a social worker or a primary school teacher in listening to his advice and expecting him to act responsibly.

So we find that CMH wants residential provision (for the handicapped) separated from the provision of special services... '... residential accommodation should be scattered throughout the community using ordinary housing provision. With appropriate staffing and staff support such a system of residential alternatives can be shown to give high quality residential care to all, including very severely handicapped clients.' The special services of therapy, training, etc, for mentally handicapped people should then be provided by schools, GPs, general hospitals, sheltered workshops run by housing, education and social services as far as possible. Multipurpose hospitals would be phased out, and of course the doctor will have no responsibility for the provision of residences and facilities and will work on an equal level with administrators, psychologists, teachers, and other caring personnel if developmental centres are set up to provide the special services the handicapped may need.

It is difficult to take this scenario very seriously when it is likely to be more costly than the present hospital system; when it is already difficult to recruit staff for existing residential alternatives and to give them support in their professional isolation, without trying to set up a lot more in ordinary houses; and when the easy phrase 'the mentally handicapped' includes everyone from the pleasantly dim-witted and easily-led to the grossly brain-damaged and behaviourally disturbed, the physically disabled, the epileptic and the anti-social. I'd like to see CMH set out for us the ways in which they would re-locate the present in-patient populations of Harperbury or Leybourne Grange Hospitals, for instance, with a realistic statement of the staff they propose and the annual budget, for comparison with the present.

In the meanwhile, let's come back to this question of what the doctor offers. The outsider tends to think of medical work in its acute context—the diagnosis of chicken pox, the treatment of pneumonia, prostatectomy or caesarean section, where one can concentrate on the illness without needing to pay much attention to the life situation of the patient. But with chronic illnesses and chronic disabilities, such as rheumatism, asthma, peptic ulcer, psychosis, or mental handicap it is quite different. One has to look at many aspects of the patient's life and work and social relations because these interact with his illness. GPs and psychiatrists often spend a good deal of their time exploring these aspects of the whole man or woman, and mobilising specialist resources—the housing manager, the orthopaedic surgeon, the personnel officer—on the individual's behalf.

The doctor does this kind of medical work—which looks like social work—all the better because he is not fixed in a hierarchy. He is not usually employed by the hospital where he works, and there is no one set over him to limit his clinical responsibility, in contrast to the local authority employee. This freedom, plus the respect in which society still holds doctors, strengthens his power to challenge bureaucracy and win concessions for his patients. Psychologists, social workers and teachers are not as yet trained in the same way to see and fight for the whole person, nor so free to do so, nor with the same prestige. Nor do they as yet have the same professional ethic, in which responsibility to the client can mean a 24-hour burden or a requirement to act at once. In the multidisciplinary team the doctor will almost always have had more

education and training than other team members and will often have had more professional experience as well. These are all reasons why he might rationally hold the leadership. If the Campaign for the Mentally Handicapped wants things to be different, they have to show us how the patients, their relatives and the community are going to be at least as well cared for. Who is going to be the patient's friend and defender, the co-ordinator of care, the maintainer of continuity? Who is going to view the patient as a wholeness, if the doctor is to be displaced? Some of our non-medical professional associates are in such a hurry to get rid of us that they haven't even stopped to grasp what we try to do. However, the role will remain, even if we go. Let us hear how they propose to play it.

CHARLES SNODGRASS

REPORTS AND PAMPHLETS

Report on the Medical Services for Prisoners. Report of a Day Conference held by King's Fund Centre and the Howard League for Penal Reform. London: King's Fund Centre. 1978 £1.00

When the Howard League raised the question of holding a public meeting on the problems of the medical services for prisoners, I suggested that this would achieve very little but lead only to a series of bromides from the principal speakers and totally disruptive behaviour among the public audience from those with individual grievances, gleefully recorded by armies of the Press. The recent painful result of the well-intentioned meeting on prostitution, held in the Central Hall, is an example. The alternative suggested was to hold a private conference of at most fifty interested and professionally involved people and take care to cover every facet of the informed and experienced—prison medical officers, forensic psychiatrists, criminologists with medical knowledge, members of the Home Office, prison governors, probation officers, psychiatrists who have had experience of being medical officers. It would be chaired by a universally respected prison medical officer and governor, Dr Gray from Grendon Prison.

The King's Fund collaborated most generously by providing their excellent small conference hall, with a cold lunch between sessions, and they have now produced this fifty-page document. It should be read along and especially between the lines by all those remotely concerned with forensic psychiatry. In a way, it is even more important that it should be read by consultant psychiatrists who think they are not concerned in forensic work, though in fact all invariably are. There is no future for the psychiatric treatment of offenders if they assume that it ought to be dealt with entirely by a specialized service, however necessary this is.

From the first, the conference ran into difficulties, which increased with the preparation of a report. In a curious way, the subsequent vicissitudes of the report reveal the nature of the basic problems even more vividly than the report itself.

First, Dr Gray fell ill immediately after the conference, though fortunately he contributed valuably to the discussion. Five or six of the most experienced prison medical officers were invited, but none 'found it possible' to attend. Dr Pickering, recently retired, and Dr Orr, the present Director, could not attend, and Dr Ingrey-Senn, Deputy Director, represented the whole service apart from those few who had once been in it. It was announced that the four main speakers, Dr Ingrey-Senn, Dr Bluglass, Dr Bowden, and Dr McKeith, would have their full papers published, but there was a guarantee that the identity of those taking part in the taped discussion would not be revealed in any subsequent publication. Not everyone took part in the discussion, which was nevertheless extremely successful and interesting, touching upon every aspect—constitutional, ethical, medical, administrative, organization, etc. There are as many legitimate views as there are 'experts', and they require serious and calm discussion.

After the conference there was controversy about whether the undertaking was that the discussion would be anonymous or would not be published at all. As a result all speakers were circulated with a transcript of what they said. Only one or two had any objections to their names being attached to their remarks when suitably edited—most people repeat themselves several times in the course of their discussion. One or two preferred anonymity, which was then given to all. In order to avoid any justification for 'breach of promise' Dr Ingrey-Senn finally agreed to every word of the last and heavily bowdlerized version, in all a

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