opinion & debate

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PHILIP SUGARMAN AND SESHAGIRI RAO NIMMAGADDA

The College and the independent sector†

Independent psychiatry beyond the National Health Service (NHS) is growing in the UK. However the history of the College can lead it to be NHS-centred in its outlook. Psychiatrists engaged in 'private practice' have at times been excluded from their collegiate peer group. We explore here the underlying and challenging issues of professional values, stigma, and occupational motivation. In the spirit of its commitment to raising standards, it is pleasing that the College is beginning to look beyond the NHS, supporting the professional development of non-NHS members, and including them in quality initiatives. We must all discover the value for patients in an open and independent perspective on what drives psychiatry in the UK.

The College and the UK National Health Service

The origin of the Royal College of Psychiatrists dates to the formation of the Association of Medical Officers of Asylums and Hospitals for the Insane in 1841 (Royal College of Psychiatrists, 2006). As the Royal Medico-Psychological Association, the College saw the NHS come into being in 1948, through nationalisation of the hospitals with whose history its own origin was so closely entwined.

Since 1948 the overwhelming majority of UK psychiatrists have therefore followed careers and cared for patients in a government service. College business has naturally been largely concerned with NHS services. However, with the growth of independent practice, the profile of College members has changed.

A few charitable hospitals, explicitly recognised as 'pioneering', were allowed to remain outside the NHS in 1948, and formed the kernel of the future independent hospital sector. Some began to provide places for NHS patients (for an example see Foss & Trick, 1989). The closure by the NHS of the large county mental hospitals in the ensuing decades created a growing market for the independent sector, despite developments in community care. In addition, national prosperity supported the growth of insurance-funded hospital and out-patient care, and the long-term development of private psychotherapy.

†See p. 407, this issue.

Private and Independent Practice Special Interest Group (PIPSIG)

A proposal for a College special interest group in 'private practice in psychiatry' was put forward in the late 1980s. The Private and Independent Practice Special Interest Group (PIPSIG) is now one of the largest special interest groups. Members include those with purely independent practice and many who also work in the NHS. Indeed it seems clear that the majority of NHS consultant psychiatrists, during their career, engage in some variety of professional work outside of specific NHS duties. The membership of PIPSIG, currently around 1000, could therefore be much larger. PIPSIG members have highlighted diverse roles outside the NHS as follows:

- direct employment by the independent sector, mostly in secure services
- visiting practice with admitting rights to (mostly acute) independent hospitals
- private psychotherapy and out-patient psychiatry
- medico-legal expert work, particularly forensic and child psychiatry
- Mental Health Act Commission, review tribunal, parole board, inquiry work, etc.
- Active psychiatrists retired from the NHS, in all the above roles
- Other non-NHS employment, for example the armed forces, pharmaceutical companies.

Psychiatrists in independent practice are an important minority group. Although formal representation remains limited, it is fortuitous that two independent sector psychiatrists were individually elected as members to the College Central Executive Committee in 2006. However, this highlights that apart from PIPSIG, non-NHS psychiatrists do not as yet have an assured voice in key College forums such as faculties and divisions.

Taboo issues: values, stigma and rewards in and out of the NHS

Psychiatry in the UK has long battled with professional stigma (Turner, 1991), and it is notable that psychiatry was one of the later specialties to receive a Royal Charter. Within psychiatry the College consciously addresses the

opinion & debate

stigma of mental illness and intellectual disability; and also the diversity of its membership, regarding ethnicity, gender and disability, and between countries at home and abroad. Some College members may however be surprised that PIPSIG members sometimes experience hostility, apparently borne out of 'NHS-centric' stereotypes. Although attitudes vary greatly, there appears to be a significant prejudice for some, that the motives of private psychiatry are less honourable and noble than NHS practice. This view is based on beliefs, which, stated bluntly, might include:

- the independent sector 'bleeds' the NHS of money and trained staff
- the independent sector pays exorbitant salaries and attracts mavericks
- private and retired psychiatrists are out of touch and incompetent
- single-handed practice such as private psychotherapy is fringe medicine
- independent sector services are of poorer quality than NHS services.

These beliefs sometimes find their expression in loaded remarks, which often appear to have a projective element. The containment provided by awareness of diversity and stigma is absent. The authors believe that exploring this difficult interface may be key to a deeper understanding of how psychiatry can progress as a vocation, and as a valued profession attractive to the next generation of doctors.

PIPSIG wishes to promote the positive values of independent practice in mental healthcare, and to see more honest psychological awareness of occupational motivation. A key value for many independent psychiatrists is a personal commitment and focus on clinical work, with comparatively less time spent on administration and committee work than NHS colleagues. Reward for many is linked directly to their clinical workload and to patient engagement, a good example of 'the money follows the patient'. Rates of remuneration are set by the market, which is dominated by the reward structure for doctors in the NHS.

In independent practice patient care is prioritised ahead of the personal long-term security of psychiatrists. In general, resources are not channelled into generous government-style pension and 'merit award' schemes, as most independent employers do not see sufficient value in these for their organisations or for patients. Few NHS psychiatrists are aware that the capitalised value of their pensions (e.g. calculated as a taxable lump sum used to buy retail-prices-index-linked annuities at age 55) is enough to physically re-provide the small in-patient or large community unit from which they retire. Interestingly, a factor in redressing the Victorian stigma around psychiatry was the granting of pensions to asylum officers in 1902. This event was candidly described as 'the most auspicious in the history of the association' by Dr Bevan Lewis, then President of the College's predecessor body (Turner, 1991).

There are many examples of innovation and effective services addressing unmet patient need on a large scale in the NHS and the independent sector, and shining examples of clinical excellence in both. Individual practitioners learn and develop in their work, and altruistically support and train others. Of course occupational motivation and clinical standards vary in both sectors too. We are probably all aware of examples of poor practice.

Challenges of independent practice – dusty answers and fresh ideas

A number of problems are repeatedly raised by PIPSIG members, who often ask for help and advice from the College. These are:

- professional isolation, and how to link with a professional peer group
- accessing relevant continuing professional development (CPD)
- appraisal and revalidation requirements.

An important recent survey of non-NHS College members by the College CPD Committee confirmed that retired members in particular experience special problems in fulfilling their CPD and appraisal requirements. A theme in the views of respondents was that 'there is no special attention given [by the College] to the needs of psychiatrists who work outside the NHS' (Gunn, 2007). A positive conclusion was that the CPD peer group 'is an ideal model to cope with the problem of professional isolation' (J. Gunn, personal communication, 2007). There are already many examples of these 'mixed' peer groups and CPD events. However, some respondents recounted having 'received dusty answers' when enquiring about peer groups with NHS colleagues.

The College Appraisal Scheme is another example of positive work – this time by the College's Special Committee on Professional Governance and Ethics. With support from PIPSIG, a creative scheme to provide College training and approval to designated appraisers of non-NHS members was developed. Unfortunately, this welcome proposal has had to remain on the shelf, pending finalisation of new revalidation systems for doctors, in the prolonged aftermath of the Shipman case, an extreme instance of isolated and aberrant practice in the NHS (Smith, 2004).

An example of professional exclusion, recently addressed, is that for many years psychiatrists who did not have NHS trainer status were not eligible to become Examiners for the College. This was raised by PIPSIG with the Chief Examiner, and a number of non-NHS psychiatrists have now been appointed as Examiners. Similarly, independent providers have generally found it difficult to break into the public sector circles of medical training and university research, although there are some notable exceptions.

PIPSIG meetings generate many ideas for services that members would like the College to provide. These include setting minimum standards for Healthcare Commission inspection of medical staffing in independent psychiatric services (as suggested by the Mental Health Act Commission, 2006), and special CPD events. This

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opinion & debate

paper is intended to create a dialogue and widen the channel for such ideas.

Partnership between the independent sector and the NHS

The present Government plans to 'bring down old-fashioned barriers' in healthcare, and to increase private sector involvement in the NHS, while retaining a service free at the point of delivery (Department of Health, 2000). Currently the independent sector provides many specialist services, including much of the secure provision for adults and adolescents, people with intellectual disability and those with brain injury. This exemplifies key independent sector values – innovation and responsiveness. Resources are identified and devoted to areas of unmet need at a quicker pace, meeting public health priorities.

As the NHS becomes more pluralistic, there has been a move towards providing patients with more choice, initially in elective surgery. The long-term aim for the NHS as a commissioning service envisages a 'level playing field' of providers, including NHS foundation trusts, voluntary not-for-profit and commercial organisations. Each of these can bring a different approach to healthcare. The commercial sector can attract capital investment, and deliver new facilities for patients more rapidly than the NHS. The voluntary sector in mental health has a long history of innovation, adding value in key areas, including the cutting edge of specialist hospital care and community mental healthcare.

The level playing field will require the NHS to experience the same regulatory scrutiny as the independent sector. The Healthcare Commission is working to reconcile its different approach to the two sectors, which have different legislative backgrounds (Healthcare Commission, 2005). The College will need to develop a similar approach to quality assurance, and it is pleasing that the independent sector is increasingly involved in College quality initiatives (see Royal College of Psychiatrists' Research and Training Unit website at http://www.rcpsych.ac.uk/crtu/centreforqualityimprovement.aspx).

Conclusion: the College must look beyond the NHS

There is an opportunity at the present time for all the medical Royal Colleges to take big steps into the future, to recognise the fundamental structural changes in UK healthcare, and to reach out beyond the NHS in many different ways. Leaders in the College have shown such vision in recent times, taking the College closer to users and carers, and other mental health charities. Changing attitudes are also reflected in the increasingly positive approach of College departments to independent sector members.

We believe that the real business of the College is to be an independent professional body, focused above all else on raising standards across psychiatry. Inclusiveness must be a priority, addressing professional isolation in every area, promoting professional development and peer-group working. Psychiatrists should capitalise on their skill base, and address the unconscious dynamics around the NHS, 'private practice' and professional motivation.

There is a fundamental challenge here – can the College recognise diverse perspectives beyond the government service, and pursue an open approach as the best way to raise standards for patients in every area?

Declaration of interest

Both authors are trustees of the College and employed in the independent sector.

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Philip Sugarman Chief Executive Officer and Medical Director, St Andrew's Healthcare, St Andrew's Hospital, Northampton NN1 5DG, **Seshagiri Rao Nimmagadda** Consultant Forensic Psychiatrist, Priory Secure Services, Thornford Park, Berkshire

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