The College

The New President

Dr Jim Birley will take up office as the new President at the Annual Meeting in July. He has been Dean of the College since 1982. Previously, he was Dean of the Institute of Psychiatry from 1971 to 1982. He has been a Consultant at Bethlem Royal and Maudsley Hospitals since 1968. He has a particular interest in social psychiatry and the care of persons suffering from long-term psychiatric disabilities.

Dr Birley writes: I have led a sheltered life, being born in 10 Upper Wimpole Street where my father practised as a neurologist, and my mother campaigned for the League of Nations, refused to help in the General Strike, and voted for the Labour Party. My father died when I was five years old. In psychiatric terms, this would probably rate as the most significant event of my childhood. In practical terms it meant that my mother settled with her young family in the home of her parents in Essex. I grew up in an 'extended' family, on a farm, and acquired a strong taste for village life, the planning and planting of gardens, and the exhilaration of playing silly games. With no one to rebel against, I followed my father's footsteps to Winchester, University College, Oxford, and St Thomas's. As a National Service medical specialist in Germany, I was alerted to the possibilities of psychiatry by witnessing the remarkable effects of treatment on the wife of a friend. This, and a chance encounter, at the RSM, with Dr Tony Isaacs, at the time a recent and enthusiastic convert to the Maudsley, were the lucky accidents which let me into a speciality where chance has always played an important part.

I enjoyed the intellectual stimulus of 'The Maudsley', but was vaguely aware that it seemed divorced from many of the realities of the rest of psychiatry. Considering what these realities had been, this was no bad thing. But the time had come to take the plunge into looking after a population as well as developing a subject. This has been my pre-eminent interest. It has always been obvious to me that such an enterprise, in terms both of service and of research, is far beyond the capacities of psychiatrists working on their own. The multidisciplinary approach, both academic and practical, is, in my view, a necessity, not a fad. This situation presents a healthy challenge to psychiatrists and to the College. If we maintain and develop our own high standards, our response to such a challenge can only be productive. We have much to teach others, as well as much to learn from them.

My initial contact with the College occurred at the time of its gestation, as a member of the 'Petition Group'—an awkward squad who were protesting that our founders were too concerned with their new examination, at the expense of the training which should go with it. (Many members of that Group now hold high office in psychiatry and in College affairs.) Since arriving as Dean, I have been immensely impressed by the energy and imagination with which trainers and trainees have applied themselves to improving our educational standards. The membership of the College contains a wealth of talent. It will all be needed in the years ahead. In our ever-fascinating human predicaments, nothing stands still.

Psychiatrists and Psychologists

Working together for planning services in the post-Griffiths era

At the College's Autumn meeting in 1984, a joint British Psychological Society (BPS)/Royal College of Psychiatrists Conference took place on the theme 'Psychiatrists and Psychologists—Co-operation or Confrontation'. This was reported in the *Bulletins* of the College (June 1985) and of the BPS. It was generally agreed to have been a success, but perhaps at the price of being over-polite. A 'more focused and hard hitting' meeting was suggested for the future.

The future came to pass on 29 October 1986 at Kensington Town Hall—picketed rather discreetly by scientologists. In preparation for this meeting five College Groups, together with clinical psychologists working in the same fields, had been allocated a task: to address three critical problem areas in planning and in providing services for their specialty which involved the two professions, and to make feasible suggestions for improvement.

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The proceedings began with a plenary session addressed by Professor David Goldberg and by Mr Steven Flett.

Professor Goldberg began by pointing out that the multidisciplinary team sprang from the recognition that medicine did not of itself have the answers to the diagnosis and treatment of major mental illness. But the original team worked on a hierarchical basis. He recalled his introduction to this at the Maudsley, where the keys issued to the staff varied in their opening power according to rank and status. Professor Sir Aubrey Lewis was said to have a key which could lock everybody in or out. The old-style team had experienced an apocalypse, brought on by the four horsemen—Seebohm, Trethowan, Briggs and Griffiths, and was now obsolescent.

While appreciating the need for professional independence, Professor Goldberg warned that "those who work only in the environment of their own profession tend to develop the idea that if someone cannot be helped by their own brand of intervention then they cannot be helped at all, and can therefore be discharged to suffer on their own". The patient would be left to wander or bounce from one unicellular service to another, when what was required was a more complex and integrated response. Another danger was the move, by clinical psychologists, away from the most seriously ill patients to the more 'rewarding' ones, particularly in general practice. He wanted to remind psychologists that psychiatrists had always been their most persistent and loyal advocates. General practitioners and paediatricians might turn out to be fair weather friends when the financial climate turned nasty.

It was therefore essential, if the multidisciplinary team was to survive, to reorganise and reassess relationships between the disciplines, and to organise services in such a way that specialties have clinical autonomy within a defined remit. 'Obsolesence' should be confined to the concept of the clinical psychiatrist as the *Oberführer* of the team.

Professor Goldberg suggested three points for a blueprint for a mental illness service:

(1) Both professions should have the same Griffiths Manager.
(2) There should be a clear distinction between 'medical' and 'clinical' responsibility. The former has to be held by a doctor, the latter belonged to many clinical professions, and certainly to clinical psychologists. If a psychiatrist was asked by a clinical psychologist to give an opinion on a patient, that did not mean that he should 'take over' clinical responsibility.
(3) Every psychiatric team should have a clinical psychologist attached to it.

AM Session

The issues of 'Responsibility' and 'Authority' were taken up by the second speaker, Mr Steven Flett, standing in for David Castell. He remarked that the quarrels between psychiatrists and psychologists displayed some of the characteristics and strategies of marital disputes: insulting each other's backgrounds (or training), arguing about who does what ("I do all the chores". "You've no time for what I want to do"). Also, as with marriages, differences sometimes escalated to a point where outsiders (e.g. general managers) intervened. Perhaps the professions needed a handbook of fair confrontation such as the book *Intimate Enemies* provides. Perhaps we needed to map territories, compare definitions and perceptions.

In this spirit, Mr Flett referred the audience to the very useful report, recently published by the BPS, on 'Responsibility issues in clinical psychology and multi-disciplinary teamwork' produced by the Division of Clinical Psychology. This defines and discusses different types of responsibility. The report confirmed and supported the statements made by the College on the difference between 'medical' and 'clinical' responsibility. But other types were also discussed such as 'prime', 'primary', 'professional', and 'ethical'. The concept of 'ultimate responsibility' was shown to be a myth—and a weapon.

Allied to 'responsibility' were different types of 'authority', accountability and autonomy. In particular, there was a difference between formal authority and personal power and between formal accountability and 'felt' responsibility. Mr Flett reminded the audience that individuals cannot and should not be held accountable for matters over which they have no authority. He added that the BMA and MDU would surely be horrified at the range of people and events that some psychiatrists claim responsibility for.

Just as 'ultimate responsibility' and authority may be used as attacking weapons in organisational and interprofessional battles, so 'autonomy' is often claimed in defence. Once again there is a need to be more specific and contextual in the use of this term. 'Clinical autonomy' refers to freedom and discretion in casework. 'Practice autonomy' refers to freedom and discretion in running a service. In many circumstances, an individual professional might enjoy a lot of the former and very little of the latter, yet the constraints on 'practice and service' might well affect individual clinical autonomy. In the end such issues must be incorporated into an agreed policy and there are now many training events to facilitate clearer policies and more effective teamwork. In the absence of policies agreed by the professionals involved, at least some constraints and priorities are likely to be imposed on warring teams by zealous general managers.

J. L. T. BIRLEY
Dean
Royal College of Psychiatrists

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