columns

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE (2006) *The Management of Bipolar Disorder in Adults, Children and Adolescents, in Primary and Secondary Care*. London: NICE. http://www.nice.org.uk/page.aspx?o=cg38niceguideline

***Richard Hodgson** Consultant Psychiatrist, Lymebrook Centre, Stoke-on-Trent ST5 7TL, email: richarde.hodgson@northstaffs.nhs.uk, **Nanda Dayalan** Senior House Officer, Lymebrook Centre, Stoke-on-Trent

Doctors should manage doctors

I completely agree with Dr Palin's assertions (*Psychiatric Bulletin*, September 2006, **30**, 353) that 'psychiatrists should be selected for management roles on merit rather than simply because they are a doctor' and that psychiatrists should aspire to 'provide clinical leadership to all clinicians working within mental health services' – not just the doctors.

The main point of the paper by Griffiths & Readhead (*Psychiatric Bulletin*, June 2006, **30**, 201–203) to which Dr Palin refers was to identify the problems confounding those aspirations – lack of clarity in roles assigned to medical directors and managers, lack of sessional time and support to do a good job, and lack of clarity in the capabilities and training required. Even those with outstanding qualities for leadership may falter under such conditions.

The inference of Dr Palin from my summary of the Kerr/Haslam Report (*Psychiatric Bulletin*, June 2006, **30**, 204–206) is the opposite of my own. The report concluded that one of the reasons psychiatrists got away with abusing patients for so long was because consultants were 'all powerful'. Dr Palin fears that in promoting *medical* management the College may be sustaining the idea of 'all powerful consultants' having a right to key leadership positions irrespective of merit. Not at all, it was the absence of powerful well trained medical managers in the 1970s and '80s that allowed a powerful consultant body to block scrutiny of consultant practice unless there was undeniable evidence of malpractice.

Psychiatrists will only gain credibility as leaders of other professions when they are managing their own profession well. As the Chief Medical Officer's recent review of medical regulation confirms that is as yet far from sorted (Department of Health, 2006). He endorses the need for powerful managers, who are doctors themselves and therefore capable of sensitively managing performance of doctors. Uni-professional line management is usual in healthcare systems so that highly specialist workers can be understood and supported in the finer nuances of improving clinical practice by individuals with similar training and experience. Confidence in recognising and tackling unsatisfactory practice early in specialist areas is essential.

The College initiative in appointing a Vice-President to engage medical directors and managers in divisional and national networks, and with the College through a central Medical Director Executive, is proceeding along the lines Dr Palin seems to support (see *Psychiatric Bulletin*, September 2006, **30**, 355–356). Collaboration with chief executives and the National Institute for Mental Health in England is seen to be the right approach for developing leadership roles and training for doctors along with other professions.

Redefining the role of medical director for the future is regarded as a fundamental first step to making things happen. Any medical director (or head of psychiatry in a trust without a medical director who is a psychiatrist) who has not yet received an invitation to a workshop on this subject please contact me.

DEPARTMENT OF HEALTH (2006) *Good Doctors, Safer Patients*. Department of Health. http://www.dh.gov.uk/assetRoot/04/13/72/76/04137276.pdf

Peter Kennedy Vice-President (Medical Management), Royal College of Psychiatrists, 17 Belgrave Square, London, email: peter@kennedy89.freeserve.co.uk

https://doi.org/10.1192/pb.31.1.35 Published online by Cambridge University Press