in other specialties, although they spend less time in direct clinical work and more time in other activities. The concern expressed in our 1974 paper that a misleading impression of our work is given by the current methods of collecting statistics by patient attendances only, is still valid.

Less than half of our group have any junior psychiatric trainees; similarly in Walk's study of 337 child psychiatrists (D. Walk, 1981, personal communication), 59 per cent of consultant child psychiatrists in hospital settings and 34 per cent of those in child guidance clinics had trainees.

Summary and conclusions

A group of consultant child psychiatrists working in or near London have compared the way they use their time with a similar study done in 1974. The 'teaching' consultants are working less overtime than formerly, but the group as a whole works a similar amount of overtime to colleagues in other specialties. More teaching and research is undertaken by 'non-teaching' consultants than in 1974. More child psychiatrists in our study are working whole-time or maximum part-time than in 1974.

There has been no change in the proportion of time spent on direct clinical work, and surprisingly no apparent increase in administration, in spite of the proliferation of NHS committees since reorganization. However, it is clear that present methods of collecting statistics by patient attendances only is seriously misrepresenting the volume and scope of the work done by consultant child psychiatrists.

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REVIEW BODY ON DOCTORS AND DENTISTS REMUNERATION (1977) *Appendix D: Survey of Consultants' Pattern of Work and Responsibilities in the NHS*.

Secrets and Gossip: Staff Communication

PETER BRUGGEN (Consultant Psychiatrist), BARBARA BRILLIANT (Head Teacher) and SUZANNE IDE (Nursing Assistant), Hill End Adolescent Unit, Hill End Hospital, St Albans, Herts.

We get in a muddle about responsibility and in our communications. Doctors are not the only ones who can discharge patients from hospital—patients can do that themselves (Teeling-Smith, 1979) and the myths about medical responsibility (as if patients are not responsible for themselves) exacerbate feelings of inequality. We are responsible for ourselves and our work; not for our patients or colleagues, much as we may care for them.

We encourage patients and clients to be 'open and direct' in their communications with us, while we avoid eye contact with colleagues in the corridor and in our meetings have a taboo on our own rivalries.

Towards each other's faces we may be friendly, while in their absence we may run down colleagues, administer or prescribe for them ('X is so disturbed he should be working somewhere else').

First names may be used down hierarchies, but not up. In clinics, the social worker makes the tea; in hospitals, the nurse. In many places doctors still have special treatment over dining rooms, personal telephone calls and parking spaces.

After being bored by what a colleague has said at a case conference or meeting, we pander, reassure or flatter, by lying. Rather than confront colleagues who may not be pulling their weight, we propose spending more to employ extra staff.

Knowledge of the experience of being in charge is withheld from juniors, who are later promoted to face the very problems which they have never seen handled.

People do not feel secure to confront their seniors when administrative decisions regarding them (over rooms, teams, duties, privileges, study leave, promotion) are taken in their absence.

The traditional system is 'vertical' and hierarchical. Formal decisions are made at the tops of hierarchies, to be carried out later by people at the bottom. Memoranda, notices and the 'grapevine' flourish.

Meetings have been introduced to change all this, but unfortunately they have been run with the same conventions, so that people come out of them without having said what they felt, and decisions continue to be made in the corridor. Confrontation occurs only downwards.

Our own method

In this small institution (with a total staff, including part-timers, of under 30), relationships between the disciplines developed through their coming together as independent groups—multidisciplinary but not interdisciplinary. Secrecy and gossiping about each were frequent.

We decided to have all grades of staff involved in management, with the hope of increasing the status of decisions made and the commitment of staff to them. We also wished to continue to have staff meetings to examine staff conflicts and to understand staff relationships, but wished to prevent

administration from being used as a defence against feeling. (How could a junior nurse's anxieties be heard when a senior member of staff brings information from a management meeting?) We decided (i) to be strict about the boundary between our private and professional lives; (ii) to separate administrative work from work on staff relationships; and (iii) to aim to have no secrets about work and to talk about people only in their presence.

We aimed to carry out these changes without abdicating staff authority, because we value that very highly and use it in our work with the adolescents (Bruggen, 1979).

Administration meeting

The administration meeting is from 10.00 to 10.30 on Mondays to Fridays. Staff and students take the chair in rotation. The secretary takes minutes, and copies are available by midday.

Under minutes, matters arising, priorities, reporting back or matters for discussion, all the administration of the Unit is dealt with. The open choosing of teams for the various meetings and consultations makes 'corridor' decision-making and clique formation less likely.

Applications for support for study leave are discussed in this meeting, with the applicant present. Requests for references and intentions to apply for other jobs are minuted. Choosing people for various tasks such as chairing meetings, being with visitors, supervising adolescents, inspecting the building, are decided in the meetings. Decisions about staff appointments, made internally or by 'statutory' outside committees with unit representations, are minuted.

Staff meeting

The staff meeting, which lasts an hour, is attended by both morning and afternoon shifts of nurses as well as '9 to 5' staff such as doctors, social workers, social work students and one member of the school staff. Night staff attend some of these meetings. The secretary and domestic do not. There is no chairperson, but each makes a statement about what he or she is feeling and may make a 'bid' for the agenda so that new and junior members are not neglected. Someone may wish to discuss an issue or problem or confront a colleague ('I have something to say to you, Jack'). Common statements are 'I feel energetic'; 'I feel tired'; 'I feel sad after that (earlier) meeting'; 'I feel I've got too much happening, but it is mostly outside of the Unit'; and 'I feel depressed'.

The ground rules are important. First names must be used—another attempt to tackle some of the restricting influences of hierarchy. Staff are expected to speak in the first person, making 'I' statements (with 'I' rather than 'one' or 'you' as the subject of sentences). Discussion should only be with people who are in the room, so that colleagues are not discussed in their absence. Work matters only should be discussed.

Because it is so easy to rationalize our own personal difficulties in terms of patient problems, we aim not to discuss patients in staff meetings but only in meetings in which they are present. On the other hand, anxieties about patients, or work with them, may be discussed. We aim to say what is on our minds about our work and our colleagues.

The practice

Sometimes it may be easier to quarrel than to express positive feelings. Angry, loud voices were common when we thought that to be 'sincere' meant to shout, but nowadays such behaviour is often thought of as a defence against sad or warm feelings, or simply against looking at one's 'own part' in something. Censorship is, however, inevitable (we think faster than we talk), but we hope that we may be asking ourselves: 'What is it about work that I am thinking, but not sharing, not because of lack of time, but because of feeling unable or unwilling?' Angry exchange between others in the room can easily be used to screen that question.

Other results

Since the senior administrators opened their communications, did we really find that other members of staff had contributions to make? Soon afterwards, the charge nurses suggested that they move their midday handover to a meeting with patients (Bruggen *et al*, 1981). Later on, a patient suggested that they should do the handover, and later, chair the meeting. One of the staff suggested that there should be a brief statement by the chairperson (a patient) about the staff in that meeting. The adolescents suggested that they give the handover to the night staff. After staff had started to call meetings if they were anxious about something and did not want to wait until a scheduled meeting, the adolescents suggested that they too should be able to call meetings. All of these have been implemented without the difficulties feared by some staff. Punctuality seems to be improved with the possibility of more direct confrontation. A nursing assistant introduced new therapeutic approaches such as bio-energetics, gestalt and guided fantasy, which led to formal training of all staff. Now the charge nurses run such groups four times a week. This has led to less violence in the institution and influence on all our work.

Are decisions delayed?

Of course decisions are delayed more than we wish, in this as in any other system but, by naming names, at least we know which of us is responsible. Within the clinical setting, decisions seem to be made more promptly than they used to be.

The coming and going of staff

The most important decision for staff is the decision about the membership of the staff group itself. Statutory committee structures control our representation for some appointments, but in the administration meeting all staff can have a say in shortlisting and all staff can meet applicants,

who are invited to visit and attend a staff meeting. Staff feel more able to welcome the decision of an appointments committee if they have been able to express their views to the Unit's representative; and newcomers feel reassured that many people had a say in their coming.

Staff who are leaving announce their intention at an administration meeting and, during their last staff meeting, a time is set aside for saying anything which, if not said, will be afterwards carried by the one leaving, or by those left behind.

The private/professional boundary and feelings of staff

Staff workshops, which have explored new therapeutic approaches such as psycho-drama, role play, 'sculpting', fantasy work, body-work and gestalt, have helped us to respect our own emotions. A common experience has been 'something happened for me'—a memory from the distant past or a vivid feeling coming into consciousness. These are not therapy groups, and while we hear and support each other, encouragement to share more than is volunteered is not given. It is noted, however, that the private/professional boundary has been met. Because we have become used to seeing ourselves and each other when we are feeling things intensely, it is easier to be more open in showing feelings in staff meetings.

The status of tears is interesting. To laugh loudly with amusement, or to shout with anger, is seen as being free; while to cry is often seen as 'breaking down'. Now we are more able to see crying in staff meetings as just another part of being.

Space does not permit lengthy verbatim excerpts from staff meetings, but comments can be made on some points which seem to stand out. Firstly, the open expression of feelings ('I feel resentful that you, Andrew, are going out on that meeting and not me'; 'I feel angry with you after what you said'; ('I appreciated your support when I was finding things difficult yesterday'; 'I feel you're not communicating with me, I want more attention from you' (nursing assistant to nursing officer). Secondly, checking things out with a person ('I feel I'm being got at by some of you, but I don't know if it's just in me. Have you been trying to get at me?'—to each person directly). Thirdly, airing conflicts and problems ('We are avoiding talking about which of you two we want to be the next charge nurse'; 'The positive thing about you is X and the negatives are Y'). Fourthly, one of the most difficult, discussing in a staff meeting one's wish for a colleague to leave.

The inevitability of conflict and the limitations of the support group

We do not advocate a free-for-all run as if the loudest is right. The bully in each of us must be reminded that there is always a more inoffensive way of saying anything. Risk-takers are always needed. If we are feeling that a staff meeting does not seem safe enough for us to talk freely, we must remind ourselves that it might be an experience, not of the 'other' but of the 'self'. Risk-taking is often called for. We are still tempted to air our work worries or to talk about colleagues outside staff meetings, but strive to say to each other 'I think we should not discuss this here—it is staff meeting material'.

Reservations and criticism

Institutions can get carried away with enthusiaism and reality can become 'the way we see it'. Our many visitors are helpful in reminding us of the value of criticism and of our temptation blindly to accept our own status quo.

Conclusion

We think that any staff support system should be reviewed repeatedly. This paper helps us in our review.

We decided that secrecy and gossip worked against us, and decided on a structure to help check them. We are not a democracy, but our leaders can be confronted. One hospital (Dingleton; see Jones, 1968) from which we have learned much, has a series of meetings to bring all members of staff into decision-making and to change corridor gossip into creative confrontation. Do the ideas have wider application? Would more creativity ensue if they did?

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