



the columns

correspondence

New Ways of Working

Being told that New Ways of Working is a new way of working is not enlightening (tautologies are true but rarely helpful) but demonstrates the problem – it is whatever you decide it is.

Redefining the role of a psychiatrist is fine but Vize *et al* (*Psychiatric Bulletin*, February 2008, **32**, 44–45) provide another tautology – ‘a role that encompasses the full scope of the work in which psychiatrists could be involved’. What people do is whatever is decided they do but this statement does not give a new ‘what’.

New Ways of Working arose from a crisis in consultant recruitment, a mismatch between consultant expansion and training numbers (Goldberg, 2008); from perceived necessity, not choice, and as such it is a pragmatic business solution to a particular demand and resource problem, not better patient care. Changing roles is not new and was happening throughout medicine. Let’s be honest, not grandiose.

New Ways of Working is now used to legitimise redesign of any sort with services being destroyed for business reasons. Is it person centred or organisation centred? To improve the lives of psychiatrists or patients? Ironically, we will soon overproduce psychiatrists under Modernising Medical Careers while facing an impending crisis of nurse shortage.

Alternative ways of working are essential because solutions to the problems of one person, service, specialty or point in time may not be the solution for others.

Vize *et al* must be clear not only what New Ways of Working is but also what it is not. Otherwise, it becomes whatever people, including primary care trusts and trust managers, decide it is. Everything is good because it is New Ways of Working. However, ‘new’ is not enough and ‘new’ is not necessarily good!

GOLDBERG, D. (2008) Improved investment in mental health services: value for money? *British Journal of Psychiatry*, **192**, 88–91.

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New Ways of Working: fences and cuckoos

There is a clue in the capital letters: New=old, Ways=one way, Working=work avoidance. It is Newspeak.

It did not occur to me when responding to the histrionic outpourings of oppressed general psychiatrists (Jolley, 2002) that their despair would spawn a quasi-religious management sect. I drew attention to practices within other specialties which maintained morale and positive service profiles and suggested that a more equable spread of manpower would reduce the difficulties.

In semi-retirement I have experience of general and old age psychiatry reconfigured to the model commended by Vize *et al* and Kennedy, and questioned by Lelliott (Vize *et al*, 2008; Kennedy, 2008; Lelliott, 2008). Every device is deployed to separate patients and families from consultants: to fragment patterns of care and to divert (‘signpost’) expectations and responsibilities elsewhere.

This is not the work of thoughtful, caring, clinical innovation which sparked and sustained my enthusiasm, confirming that we are available, with knowledge, skills and wisdom for people wherever they are in need (Jolley, 1976). Community psychiatry, including old age psychiatry, demonstrated professional humanity and superbly efficient use of resources. Let us return to the lessons of the recent past and set aside these ugly new clothes. Those who have been led astray are not to be blamed, but understood and thanked for the challenge they have given us. There is always something to be learned: we can do better. Taking down fences rather than sitting on them or jumping from them might be a good idea.

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KENNEDY, P. (2008) We need to monitor implementation. Commentary on . . . New Ways of Working. *Psychiatric Bulletin*, **32**, 46.

LELLIOTT, P. (2008) Time for honest debate and critical friends. Commentary on . . . New Ways of Working. *Psychiatric Bulletin*, **32**, 47–48.

VIZE, C., HUMPHRIES, S., BRANDLING, J., *et al* (2008) New Ways of Working: time to get off the fence. *Psychiatric Bulletin*, **32**, 44–45.

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New Ways of Working: power, responsibility and pounds

We need a debate on New Ways of Working (*Psychiatric Bulletin*, February 2008, **32**, 47–48): good principles are being distorted by a range of conflicting influences – the most powerful is money (Sainsbury Centre for Mental Health, 2003). Doctors are expensive. Financial pressures encourage use of a cheaper member of staff whenever possible: replacing expensive staff with cheaper staff puts us at the cutting edge of New Ways of Working! This distorts team structure and working at all levels. Sometimes it might be appropriate, allowing highly trained staff to focus skills where needed. Alternatively it might deprive patients and families of access to expertise, and lead organisations to push staff to shoulder responsibilities which they feel are beyond their competencies or for which they are not adequately trained or remunerated.

Other pressures involve power and responsibility (General Medical Council, 2006). Undoubtedly there are people/organisations who see New Ways of Working as diminishing doctors’ ‘power’. Some fear that New Ways of Working diminishes medical responsibility, and leaves other staff carrying levels of responsibility that they are uncomfortable with, or worse, no-one has responsibility. But is power a finite package that gets cut up and doled out? Or can we become, by joining together, a more powerful force to work in the interests of patients and families?

Paradoxically, New Ways of Working stereotypes professionals. Organisations describe what different professionals do