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What does 'responsible medical officer' mean in a modern mental health service?

Dean (2001) found conflicting views among consultant psychiatrists about 'what is actually meant by having responsible medical officer (RMO) status'. Many clearly feel that they are responsible for virtually all patients referred to secondary care: Tyrer *et al* (2001) found in a large audit many consultants with big personal case-loads of 200–300 patients. They concluded that the statutory duties of a RMO needed to be revised to avoid consultants 'merely becoming bureaucratic administrators of their case-load'.

This is a matter of importance, not only for the welfare of patients, but also for the health of psychiatrists. Rathod *et al* (2000), from a large systematic questionnaire survey, confirmed high levels of stress due to excessive workloads among consultant psychiatrists. Responsibility without a commensurate degree of influence on how multi-disciplinary and multi-agency services are developing in the community compounds the problem, and possibly accounts for the high levels of premature retirement and consultant vacancies described by Kendell and Pearce (1997).

Law, policy and guidance

The role of the RMO is only enshrined in law in the Mental Health Act (1983) referring to patients receiving compulsory treatment. The White Paper on Reform of the Mental Health Act (Department of Health, 2000a) proposes that the term RMO should be changed to clinical supervisor because it will be the independent tribunal that holds the responsibility for compulsion, and because clinical psychologists as well as psychiatrists may be clinical supervisors.

College statements on 'the responsibilities of consultant psychiatrists' have been reviewed and revised over the years (Rawnsley, 1984; Royal College of Psychiatrists, 1996, 2001a). The medical care of out-patients remains as always 'the ongoing responsibility of general practitioners, with consultants acting in an advisory capacity or providing specialist treatment' (Royal College of Psychiatrists, 1996; p.10). In the 1996 document, besides being very clear on RMO responsibility for detained patients, the College is also clear that

'consultant psychiatrists retain the ultimate responsibility for all aspects of medical care of an in-patient under their care, including discharge' (p.10).

However, this 1996 College statement recognises difficulties in achieving clarity about consultant responsibility within multi-disciplinary community teams. It talks about the medical role having 'primacy in the process of assessment and/or diagnosis, treatment and issues of confidentiality' (p.17). It stresses 'that consultant psychiatrists can only accept responsibility for a patient of whom they have specific knowledge' (p.9). It expresses concern about 'reports of excessive workloads being undertaken by consultant psychiatrists' (p.7). A more recent College report (2001a) makes recommendations for increasing the numbers of general psychiatrists and containing their workloads.

A further College report (2001b) on consultants as partners in care emphasises that by statute of the Medical Act 1983, consultants 'have the ultimate responsibility and authority to diagnose illness and prescribe treatment. This authority may be delegated to other professionals but the responsibility cannot be abrogated' (p.12). In the General Medical Council (GMC) guidance notes on *Good Medical Practice* (GMC, 1998) it states that the consultant who delegates medical care to a nurse or other health care worker 'must be sure that the person to whom you delegate is competent to carry out the procedure or provide the therapy involved' and 'you must be sure such healthcare workers are accountable to a statutory regulatory body'.

The big questions, therefore, that these statements from the College and GMC leave unanswered are:

- (a) To what extent, if any, is the consultant in a multi-disciplinary community mental health team (CMHT) responsible for patients being cared for by other secondary care professionals, whom he/she has never seen, or whose care he/she is not routinely supervising?
- (b) What is, and what is not, medical diagnosis, treatment and care, as distinct from other forms of assessment, therapy or care?

Other professionals in secondary care CMHTs often provide time-limited psychosocial interventions



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or lifestyle management for individuals with enduring disabilities. Such skills are not exclusive to the medical profession. Arguably, nowadays, community psychiatric nurses, psychologists and approved social workers are at least as competent as general practitioners (GPs) in risk assessment and recognising when to ask for the consultant psychiatrist's opinion.

Current consultant practices

Kennedy and Griffiths (2001) found that consultant general psychiatrists with large case-loads have as a consequence a large proportion of the working week taken up by fixed sessions (e.g. booked clinics). Hence, they are finding it increasingly difficult to be rapidly available to assess emergencies, which are steadily rising in number in most services. Where that is the case, there tend to be higher rates of admission, and clinical audits suggest that 30–40% of these admissions could have been avoided. Wards are overcrowded and less safe because of inappropriate admissions (Sainsbury Centre for Mental Health, 1998). All these factors taken together paint a picture of the traditional interpretation of the RMO role actually reducing the safety of the service, as well as raising anxiety and stress in consultants.

The same study sought to identify consultants who seem to be resolving role and workload problems. Some consultants working in CMHTs do not take direct referrals from GPs. There is a single route of referral to the team, where allocation takes place according to who is best able to handle a case. These consultants did not feel they had to see everyone referred, but prioritise patients with more severe problems or higher risks. They delegated a lot of clinical responsibility to other members of the team and believed that legal responsibility was correspondingly dispersed. They felt that they had the support of their chief executives and trust boards to do so, so that they could concentrate on priority cases and being available for emergencies. They had smaller case-loads, fewer fixed sessions, and were better gatekeepers with fewer in-patients.

There is no doubt that the latter mode of practice is controversial with other general psychiatrists. Some felt that before countenancing such changes, they would need not only the approval of local chief executives and trust boards but also the College, the GMC and even Parliament! But it is worth reflecting here that many child and adolescent psychiatrists have been practising thus, with a triage and tiered approach, for years without it appearing to be controversial. The authors of this paper have yet to hear of any psychiatrist who has fallen foul of an inquiry into a serious incident involving a patient referred to secondary care whom they have never seen, nor been asked to see.

Service modernisation

The sheer volume of service change required by the National Service Framework (Department of Health, 1999), and NHS Plan (Department of Health, 2000b) makes it unlikely that any concept like RMO can be left

intact without fundamental re-appraisal. There will be early intervention services, crisis response teams, assertive outreach teams, as well as CMHTs whose engagement with primary care teams will be so much greater that they are also being called primary care liaison teams. In making sense of the new world, the following statement in *The Mental Health Policy Implementation Guide* of the Department of Health (2001) is important:

'Community Mental Health Teams (CMHTs), in some places known as primary care liaison teams, will continue to be a main stay of the system. CMHTs will have an important, indeed integral, role to play in supporting service users and families in community settings. They should provide the core around which new service elements are developed. The responsibilities of CMHTs may change over time with the advent of new services, however they will retain an important role. They alongside primary care will provide the key source of referrals to the newer teams. They will also continue to care for the majority of people with mental illness in the community.' (p. 6)

Safety is still paramount across all policy and service planning and there is a powerful requirement for everyone to take a 'whole systems approach' that ensures continuity of care, particularly for those patients with complex needs requiring multiple agency and professional services. Where might the consultant fit, and want to sit, within this more complex system?

The consultant could be, and some already are, the epicentre of a sector service in which responsibility for many patients is delegated to other professionals in the CMHT, and also to specialist teams containing professionals trained in these specialist functions. The crisis resolution teams should reduce unpredictable demands on the sector consultants. The assertive outreach teams should lift a lot of the responsibility from the sector consultant for the surveillance and maintenance of high risk patients who tend to disengage. The closer engagement expected between CMHTs and primary care teams, with increased capacity for mental health provision in primary care, could mean even more opportunity for delegation.

A question of paramount importance for the whole service is, who will monitor the journeys of patients with complex needs across all these interfaces and sections of the service? It is a clinical governance issue *par excellence*. Discontinuities of care are a priority concern of user and carer groups and the most common failure identified by inquiries into serious incidents. The consultant who focuses on the more severely mentally ill is certainly in a good position to do so, with two conditions: his or her personal case-load is small enough to allow time to do so; and he or she has influence commensurate to the responsibility to make sure things are quickly put right when the inevitable glitches in the system are identified.

Main options

1. Retain traditional role of the RMO

To retain the traditional interpretation of the RMO role without, as Tyrer *et al* (2001) say 'consultants being bureaucratic administrators of their case-loads' would mean a very large expansion of consultant numbers.



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More are planned, but even if the entire 12% uplift in mental health spending forecast in the NHS Plan were spent on psychiatrists it would take a number of years to train and recruit, and it would not be enough. To reduce case-loads of 200 to 300 (Tyrer *et al*, 2001) to a slightly more realistic 100 would mean doubling or tripling the number of general psychiatrists. The other consideration is that this approach might undervalue and limit the potential of other professionals in the CMHT to develop skills for the exercise of which they could quite adequately carry clinical and legal responsibility. This would be at a time when the recognised level of need for mental health services is so great as to require all the talent available.

2. Limit RMO responsibility to patients seen regularly

With RMO responsibility restricted to assessing emergencies and continued care of those at highest risk with more complex conditions, a manageable job could be created. The RMO should then have time to be available at short notice for consultation by other professionals if worried about someone moving into the higher-risk, more complex category. But would this role give best value to the NHS from highly trained and (relatively) highly paid consultants? Would it satisfy psychiatrists who want to influence and develop whole services for the whole range of psychiatric conditions?

3. Primacy but not RMO for all secondary care referrals

As always there is a middle way. With a smaller personal case-load prioritised as in option 2 above, the consultant would remain by virtue of a more extensive therapeutic range at his/her disposal sapiential leader of the CMHT. (Even those professionals who question the pre-eminence of the consultant in the team do not deny, and manifestly behave as if, the 'buck' stops with him/her for the most difficult and dangerous patients.) Thus the consultant would expect to be thoroughly involved in devising the protocols for allocation of work to other professionals. The consultant would have an appropriate degree of influence on changes of membership of the CMHT. Professional line managers would have to take very seriously doubts expressed by the consultant about competence of personnel to whom key clinical and legal responsibilities have been delegated. Some consultants on behalf of other consultants in a service would have primacy (or call it clinical governance lead) for continuity of care. Supported by a manager they would monitor and deal with interface problems across sub-speciality and team boundaries knowing that they could expect chief executive intervention where there was failure to agree. Presently, festering boundary disputes are not uncommon in trusts, to the detriment of patients and the intense frustration of clinicians (Kennedy & Griffiths, 2001).

The resolution process

We need an informed debate, on the basis of the evidence of what consultants are actually doing in different services with respect to the RMO role. Practices where there is more or less delegation to other professionals need to be tested for comparative safety, job satisfaction and user and carer assessment of supportiveness.

It is very unlikely that parliament or the GMC would want to contribute to a debate about what is practical in such a complex part of the NHS. Those who live in fear of censure should they budge from what they understand Parliament and the GMC may mean by the RMO role, need to study precedent. Are there really any consultants who have fallen foul of inquiries into serious incidents involving patients referred to secondary care whom they have appropriately never seen, nor been asked to see?

The College guidance (1996, 2001b) on the responsibilities of the consultant psychiatrist remains a very good platform from which to move on those areas that were recognised then as problematic and that have become more unclear because of new policies and service demands. Psychiatrists and other professionals do need to know that their practices are approved of by their employers, the trusts, that were constituted by Parliament to manage local services. A well worked out change in the RMO role approved by a trust board is not going to put any professional in jeopardy. Such practical and sensible re-interpretations will need to be described, evaluated and disseminated – a job perhaps for the new National Institute for Mental Health.

The fact of the matter is that some psychiatrists have already altered the definition of RMO, striving to provide a safer service and survive themselves, while some others are struggling under near impossible conditions trying to be true to a definition of RMO from a previous era.

Declaration of interest

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References

- DEAN, A. (2001) *The Consultant Psychiatrist in the New Millennium*. London: Royal College of Psychiatrists. (<http://www.rcpsych.ac.uk/members/membership/millennium.htm>)
- DEPARTMENT OF HEALTH (1999) *National Service Framework for Mental Health*. London: Department of Health.
- (2000a) *Reform of the Mental Health Act: 1. Legal Framework. 2. High-Risk Patients*. London: Department of Health.
- (2000b) *The National Plan for the NHS*. London: Department of Health.
- (2001) *Mental Health Policy Implementation Guide*. London: Department of Health.
- GENERAL MEDICAL COUNCIL (1998) *Good Medical Practice*. London: GMC.
- KENDELL, R. E. & PEARCE, A. (1997) Consultant psychiatrists who retired prematurely 1995 and 1996. *Psychiatric Bulletin*, **21**, 741–745.
- KENNEDY, P. & GRIFFITHS, H. (2001) General psychiatrists discovering new roles for a new era. *British Journal of Psychiatry*, **179**, 283–285.



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RATHOD, S., ROY, L., RAMSAY, M., *et al* (2000) A survey of stress in psychiatrists working in the Wessex Region. *Psychiatric Bulletin*, **24**, 133–136.

RAWNSLEY, K. (1984) The future of the consultant in psychiatry. A report to the College. *The Bulletin of the Royal College of Psychiatrists*, **8**, 122–123.

ROYAL COLLEGE OF PSYCHIATRISTS (1996) *The Responsibilities of*

Consultant Psychiatrists. Revised Statement. Council Report CR51. London: Royal College of Psychiatrists.

— (2001a) *Roles and Responsibility of a Consultant in General Psychiatry*. Council Report CR94. London: Royal College of Psychiatrists.

— (2001b) *Consultants as Partners in Care*. Council Report CR96. London: Royal College of Psychiatrists.

SAINSBURY CENTRE FOR MENTAL HEALTH (1998) *Acute Problems*. London: Sainsbury Centre for Mental Health.

TYRER, P., AL MUDERIS, O. & GULBRANDSEN, D. (2001) Distribution of case-load in community mental health terms. *Psychiatric Bulletin*, **25**, 10–12.

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Commentary: audit of case-load and case mix of higher specialist trainees in child and adolescent psychiatry[†]

The Child and Adolescent Psychiatry Specialist Advisory Sub-Committee (CAPSAC) of the Royal College of Psychiatrists has produced a detailed set of advisory papers covering all aspects of training in child and adolescent psychiatry, the existence of which makes the audit of training a more straightforward task than in the past (Royal College of Psychiatrists Higher Specialist Training Committee, 1999). The paper by Sharp and Morris (see pp. 212–215, this issue) is part of a continuing tradition of audit and evaluation of higher training in child and adolescent psychiatry (Garralda *et al*, 1983; Bools & Cottrell, 1990; Smart & Cottrell, 2000). In the past, supervision (or lack of it) has been a preoccupation (see Kingsbury & Allsopp, 1994). However, the most recent national survey of higher trainees in child and adolescent psychiatry suggests that the number of trainees receiving inadequate supervision is continuing to fall (Smart & Cottrell, 2000). Sharp and Morris focus instead on case-load and case mix and are to be commended for persevering over three annual cycles with an audit that clearly demonstrates changes being made in the light of data collected, followed by re-audit and re-evaluation – audit projects rarely ‘close the loop’ so clearly.

The audit found substantial variations in case-load and goes on to explore why this might be, finding an association of high case-load with deliberate self-harm (DSH) assessments and with attention-deficit hyperactivity disorder (ADHD). The CAPSAC guidance on case-load states:

‘Full time trainees would normally be expected to have a clinical caseload of between 20–30 cases at any one time and to have had some direct responsibility for the assessment / treatment of between 50–75 new cases each year. It is recognised that there may be good reasons for variations outside of these limits at some times and in some placements depending on the nature of the placement. However, significant variations over long periods would be a matter of some concern.’ (p. 6)

The intention behind this guidance is to allow trainees time to think and read about their work in order to allow

integration of theory and practice. Consistently high case-loads are therefore of concern and it is encouraging that over time the programme was able to reduce case-loads. However, CAPSAC does recognise that different case-loads are appropriate in different posts – good examples are cited within this paper for trainees in in-patient units and in research posts and those new to the programme.

Work with young people who self-harm typically involves brief interventions and drop-out rates are often high. If the trainees’ role is medication review, ADHD follow-up is not necessarily time consuming and so more cases can be seen. It is not surprising that over a 1-year placement a trainee seeing significant numbers of DSH cases or ADHD follow-up cases might breach the suggested upper case-load limit. However, CAPSAC does not expect trainees who do relatively high proportions of short-term work to stop work after 8 months if annual case-load levels are reached! The key training issue here is not the case-load but whether the cases seen are providing the depth and breadth of clinical experience required. DSH can bring a trainee into contact with a wide variety of underlying problems and aetiologies and lead to a variety of therapeutic interventions involving other agencies. A relatively high case-load because of DSH work may, therefore, be appropriate, depending on specific training needs. Similarly, trainees need experience of medication use in ADHD, although if case-loads are high because trainees are being used just for medication monitoring then the training value must be questioned if this persists over time.

Well-maintained logbooks and regular reviews of training objectives are the best way of ensuring that the balance between case-load and case mix is maintained. Audits such as this provide an additional safeguard to ensure that all trainees are receiving adequate training.

A tension for trainers is the need to prepare specialist registrars for the ‘real world’ where consultant

[†]See pp. 212–215 this issue.