Tavistock Clinic

The discovery of anomalies at this clinic led to the more extensive investigation described in the previous study. Two promotions and one new award have meant that there has been an above average share of this year's new awards, which suggests that some unusual movement is possible if information is presented clearly enough. The clinic's total allocation is still, however, left well below the national average for all consultants and under half the average for teaching hospitals. Tavistock Clinic consultants are now scoring close to the average for all psychiatrists. Perhaps this is correct. On the other hand, 11 London consultants, two already at teaching hospitals, applied for a recent consultant post at the clinic.

Conclusion

We know that some thought has been given to devising new advisory committees but in our own region nothing has changed and the quota system¹ is pressed as strongly as ever.

During the two-year period studied so far, 1433 awards have been newly distributed (nearly 30% of all awards). Nevertheless,

the pattern of distribution hardly changes at all and only very slowly. This could be because the Awards Committee have, more or less, "got it right" now. The available facts point in a very different direction.

We still advocate the abolition of the distinction awards system. Failing the official abolition of secrecy (which we consider to be urgent and essential), the publication of any other researches and information would be constructive.

¹ *British Medical Journal*, 1975, 1, 162.

² *Annual Report of the Department of Health and Social Security*, 1974. London, HMSO, 1974.

³ *British Medical Journal*, 1975, 4, 364.

⁴ *Review Body on Doctors' and Dentists' Remuneration, Supplement to Third Report*, 1973. London, HMSO, 1973.

The Tavistock Clinic, London NW3

P BRUGGEN, DCH, MRCPsych, consultant psychiatrist
S BOURNE, MRCP, FRCPsych, consultant psychiatrist

How to profit from financial difficulties

R GABRIEL

I was recently a senior psychiatric administrator in a centre known locally as the "Taj-Mahal" of children's mental health facilities. Each year the centre cost more—quite appropriately in view of its expanding services and general price increases.

A sudden political change required us to cut our budget by 18% and our complement by 10%. A sense of doom and disaster instantly befell us. A series of panic meetings was called which showed that adaptation was the only course open to us. For the first time, the actual role of the centre was seriously examined, notwithstanding the fact that lip-service attempts to define it had been made for years. A statement of objectives emerged that satisfied both ourselves and others in the region. This reduced our earlier grandiose fantasies to a clear definition of our function. We were also forced to redefine our relationship with other agencies operating in the area.

Choosing the cuts

Who was vital to our function—gardeners, child care workers, cooks, or psychiatrists? Soon certain modifications were discovered to be in the interests of our children. We realised that it was more normal and therefore more therapeutic for them to smell, see, and participate where possible in cooking. The "normalising experience" became the measure of what was to be permissible.

We questioned the existence of inpatients and thought that many of our children might be better treated as day patients or in their own homes if our resources could be redeployed. In fact, our potential as parent substitutes improved more than we had thought possible because it was necessary for the workers to develop a wider range of professional skills.

Are cheaper ways better? Of course not, except that in being forced into them the opportunity arises to re-examine the validity of much hitherto unquestioned activity. A pool of high quality expertise can maintain many other therapeutic people. Behavioural programmes at the Maudsley Hospital in London have been carried out as competently by nurses as by psychologists and doctors.^{1 2} We have much to learn from the current proliferation of self-help agencies. A small wound no more requires a consultant surgeon than does a poorly communicating family always need a consultant psychiatrist. Thus do we save money and simultaneously create better nurses

or child care workers. This has been carried further by agencies who train volunteer therapeutic parents in a manner analogous to marriage guidance counsellors.³

Controllable budget

My anecdotes make a central assumption: that budget is controlled or controllable. The line of communication between the budget-setting authority and the front-line worker is very significant. Budgeting is a political activity, and people at the front, not having participated in the political decision, rebel and either function ineffectively or overspend. People with clinical autonomy, such as consultants, produce increasing demands on genuinely believed clinical grounds and the control usually has to give way; this leads to poor quality control. Or the administration reduces services in an apparently arbitrary manner. The only solution I know which obviates this is to delegate financial decisions to the lowest possible level of the service. This allows the authority to state: "You have £x and are expected to provide such and such a service." Whenever I have been able to do this the results have been impressive: the budget has been respected and not challenged. The act of trust involved in budgetary devolution results in creative change in attitudes to solving problems—something that is almost impossible to achieve so easily in any other way.

"Achieve your goal in this way" is a bad message to give to a respected professional. "Achieve your goal with these resources" is cleaner and demonstrates trust. The public must be able to be certain that it is getting what it pays for. This is ensured by negotiating analysable indicators of clinical activity agreed by budget controllers and clinicians together.

Importance of audit

The caring professions have been remarkably averse to measuring anything that they do. They have not been taught how to do so, believe it to be impossible, and fear that they would not show up well if measured. Unchecked public expenditure should not be tolerated. Evaluation is not a big brother to be dreaded—in my view it is the tool by which clinical consciousness can be raised. At its simplest it consists of writing down three things: (1) a formulation of the problem; (2) a prediction of the hoped for aims of treatment; and (3) a list

of signals which can be monitored at prearranged regular intervals to show whether the treatment is on course. In this way therapeutic activity can be kept meaningful, changed flexibly, or diagnostic formulations reconsidered.

Conclusion

I have said that financial difficulties may be seen as a stimulus to a re-examination of our ways of working, the structure of our organisations, and the quality of our work. It is sad that we require such shocks to wake us up to possible improvements which should be happening even in affluent times. But, these are challenging times in which we can demonstrate what we really have always pretended to know: that people function

best when given responsibility and professionals never need feel any threat if called upon to be accountable to the public and their peers.⁴

¹ Marks, I M, Connolly, J, and Hallam, R S, *British Medical Journal*, 1973, 2, 156.

² Marks, I M, *et al*, *British Medical Journal*, 1975, 2, 144.

³ Blum, M, *Presentation*, Ontario Association of Children's Mental Health Facilities, 1974. Unpublished.

⁴ Gabriel, R, *New Psychiatry*, 26 September 1975.

Charles Burns Clinic, Birmingham

R GABRIEL, MRCPsych, DPM, acting consultant-in-charge

GMS Committee discusses independent practice

The General Medical Services Committee met on 19 February with Dr R A Keable-Elliott in the chair. The debate on independent practice and the NHS is briefly reported here. A report on the remainder of the meeting will appear in a future issue.

Dr Keable-Elliott reminded the committee that the Goodman proposals (27 December, 1975, p 771) had been rejected at the committee's December meeting (3 January, p 50). Once the consultants had decided to have a ballot the die had been cast because they would be showing their cards to the opposition. The CCHMS had considered the results of the ballot and their recommendations virtually meant a press campaign (21 February, p 477). The Government, he said, had every intention of introducing legislation and the consultants had decided that by holding the Prime Minister to his assurance that the Goodman proposals would be incorporated into this legislation if sanctions were lifted they would do better than with the original consultative document. They also hoped to influence the drafting of the Bill.

But the Goodman proposals were concerned with more than the phasing out of pay beds and the whole profession was affected. He asked the GMSC if members wanted to reconsider their opposition to the proposals in order to participate in exploratory talks on the proposals. The committee had also been invited to appoint two people to the "Campaign for Independence in Medicine" (21 February, p 418).

Unfortunate but predictable

For the CCHMS Mr T M Hennebry referred to the unfortunate but predictable result of the ballot but he thought that the objection to the Goodman proposals was greater than was illustrated by the result. They were merely the consultative document in slow motion. He suggested that the ballot return had been influenced by the letter sent to all consultants by the chairman in the Independent Hospital Group (17 January, p 173).

The significance of the ballot result could not be overlooked, declared Dr G W Taylor. If consultants were not prepared to resign over professional independence he did not think they would resign over anything. General practitioners and junior hospital staff might have to continue the fight to uphold BMA policy. He thought the CCHMS recommendations should only be received.

The consultants had made two fundamental mistakes, according to Dr G E Crawford: they were fighting on the wrong front and with untrained troops. The fight was for the freedom of the individual and of medicine against creeping totalitarianism. The views of the GMS Committee must be made known to the public.

All the speakers were opposed to contributing to the "campaign." Dr W G A Riddle did not think that advertising would have any effect. But he wished to take part in the exploratory discussions as he wanted the committee to look ahead to the time when the Government would attack the independent contractor status of general practitioners.

Consultants confused

Dr J C Cameron said that many consultants had abstained because they had been confused by the Goodman proposals and by the ballot. This did not mean that they accepted the proposals as a majority of them had opposed the divorce of pay beds from NHS hospitals. Until there was a completely socialist state freedom of choice must be defended and the general public had not been made aware of what was at stake. The committee had no assurance of the position in general practice. He referred to a letter from the DHSS about private practice in health centres which said that the matter would be considered again when the result of the consultants' ballot was known.

If the fight to maintain pay beds was lost, Dr Cameron went on, then the profession must fight for untrammelled private practice outside the NHS. He was, he said, heartened by the Prime Minister's statement that he wanted a strong private sector. An approach should be made to the Government that there should be no attempt at a quantitative control of private practice. The matter was not and never had been only a CCHMS problem; if all the stories about queue jumping and other abuses were true these could have been corrected administratively long ago. It was for the BMA as a whole to stand firm against the proposals. But public support was essential.

After further debate the committee reaffirmed its opposition to the Goodman proposals. It also decided, however, that if the chairman was invited to attend discussions in which the independent medical practice aspects of the Goodman proposals were to be discussed he should attend. The meeting also agreed to appoint Drs J H Marks and J S Happel as representatives to the "Campaign for Independence in Medicine" with a brief to keep a special watch on the advertising material to be sent out.