district) have directors of nursing services to whom nurses are professionally accountable but who are not responsible for controlling nursing policy, organisation, or budgets.

Further up the NHS hierarchy some regions lack effective nursing representation, and the apex of the post-Griffiths NHS, the health services supervisory board, omitted to include the chief nursing officer among its members for the first year of its existence. Regardless of the reasons for this, it was widely interpreted by nurses as a snub and symbolic of just how far their stock had fallen.

As a report on nursing after Griffiths states, "Nursing would seem to be the sort of topic that any rational health service general manager would wish to receive detailed advice upon—half the workforce and one third of the revenue budget cannot sensibly be ignored; in addition . . . nurses are in closer continuous contact with the clientele than any other part of the workforce."¹⁹

It is because nurses' salaries make up the largest part of the revenue budget that levels of nursing manpower have attracted the attention of general managers intent on making efficiency savings. Some of the ensuing cuts in staffing levels have been disastrous and would probably not have been made if there had been an adequate nursing contribution into making decisions.

Since its early nadir there has been a steady improvement in the representation of nurses at all levels. Nurses have also been appointed as general managers at regional level (1/14 posts), district level (5/192), and unit level (about 80/650).

Conclusion

Acceptance by the government of both Project 2000 and the clinical grading structure (without funding them by cuts in special duty payments) would go far to satisfy nurses' grievances about their lack of professional status and career. The government's

decision should be known in the next few months. A question remains, however: why do nurses now regard the lack of both of these so crucially important? This cannot be satisfactorily answered from within nursing. In my next article I will look at how wider social forces impinge on nursing and examine in more detail a theme touched on in the first four articles of this series: the consequences of seeing nursing as women's work.

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Personal Paper

What should psychiatrists be doing in the 1990s?

GLIN BENNET

Large numbers of mental health professionals are now working in the community and in mental hospitals. They come from various disciplines and use a variety of explanatory models. Where do psychiatrists fit in this new pattern and what will be their role in the future? Thus established psychiatrists want to know how they are going to fit in with the developing community services, and psychiatric trainees want to know how best to prepare themselves for a new and so far undefined role.

Psychiatrists are having to respond to changes in society, to the expectations of the consumers of health care, and to the contributions and philosophy of the varied health professionals currently at work in the community.

Until recently the psychiatrist was the sole responsible professional dealing with mental health problems. Of course, there were skilled mental welfare officers, social workers, child care

officers, and others, but the psychiatrist was the only one publicly accepted as an expert, and was the one who held the key to admission to mental hospitals, which was usually seen as the only option for people with pressing psychological problems.

Now things are different: new kinds of professionals are established on the mental health scene—for example, clinical psychologists and community psychiatric nurses—and some of the existing ones have augmented their skills and broadened their vision—for example, general practitioners, health visitors, and social workers.

There is an ideological change, too, which I suspect will prove to be more important in the long run than changes in management structure and clinical practice. The health professionals do not have a medical training, and so tend not to conceive the problems of living in terms of illness. These professional people are primarily interested in health, and variations on ordinary functioning are seen as far as possible in social terms; doctors, by contrast, are primarily interested in illness and so are apt to view such variations in medical terms. That is not to say that health professionals are incapable of recognising physical illness or major psychiatric disorder—far from

it: it is merely that they have a different viewpoint from many psychiatrists and general practitioners. Unfortunately, this is a viewpoint which may strike some doctors as subversive, because this view of health and its maintenance implies a recognition of the interdependence of health, housing, economics, and education, and also because the proponents of this view may adopt liberal and radical positions.

As the skilled health professionals become more familiar to the public and show how well they can deal with a wide range of social problems and the problems of living, they will expand the range of problems that they can handle until they reach the point where one asks, "What is left for the psychiatrist?" What indeed?

The psychiatrists' strength comes from having a medical education with an extensive theoretical grounding which gives them a potentially greater range of skill than other health professionals, which can help them understand and assimilate technological advances as these appear. There is an obvious role for psychiatrists in any aspect of mental disorder which touches on the physical, chemical, or genetic and so makes use of medical skill. But we now have a new generation of neuropsychiatrists, and psychogeriatricians, so what are the ordinary psychiatrists to do?

Mental health professionals are doing good work, but at the back of it, in the minds of doctors, is the question of overall clinical responsibility. Doctors talk a great deal about responsibility, but we are moving to a new era in which the consumers choose the service they want (even if it is provided by the state)—much as people choose a solicitor or a school for their children. The customers have a right to expect competent service from professional people, and the consumers of health care are becoming much better able to evaluate the adequacy of the care they receive. Where personal health or problems of living are concerned primary care doctors and, when they are concerned, psychiatrists often act as though they are personally responsible for everything that happens to "their" patients, almost as if the consumers are unable to make choices or reach any conclusions for themselves. This may be a basic principle of medical care, but non-medically qualified workers sometimes see it as a strategy to retain control over its delivery.

Then there is implementation of the Mental Health Act 1983 and the control of admission to hospitals. Though these may not be inherently attractive parts of any psychiatrist's work, they certainly carry power, which if nothing else serves to augment the psychiatrist's status.

The future

Psychiatrists cannot assume that they will automatically be in charge of the teams in which they work, and, though this prospect may alarm some, it has a good historical background.

It is perfectly acceptable in hospitals that the charge nurse or sister manages the ward and the doctor makes the clinical decisions, although in any proper multidisciplinary unit the decision making is collective. In psychiatry in the community, on the other hand, the position of the doctor is less clear; and it is here that difficulties are arising. A number of mental health professionals are doing good work more or less independently without feeling any obligation to be beholden to psychiatrists. To many psychiatrists this seems like anarchy, but I see it as a sign that we have not worked out how to run community mental health services and, in particular, what the role of the psychiatrist should be in them. Psychiatrists who assume that they ought to be in charge should remember the different philosophy of the mental health professionals and the practice in hospital wards, where the doctor does not have to be the manager.

Psychiatric trainees frequently seek advice about how much they should know about general medicine and surgery, neurology, and so on, and how much experience in general practice is desirable.

The excellent psychiatric trainees we see these days have to unlearn many of the elitist attitudes implanted by our conservative medical schools. That is not always as easy as it might seem, because the fantasy—acted out in teaching hospitals—of sitting at the top of a pyramid with all the other workers there employed solely to smooth one's progress is very agreeable and disappointing to have to

relinquish. Community psychiatry is emerging as a subspecialty, and it remains to be seen whether it will develop as hospital style practice taken out of doors or as something fresh and altogether more flexible.

1990s

Now that the euphoria about emptying psychiatric hospitals is being tempered with realism, there will probably be a role for psychiatrists in a hospital setting, although with a more intractable group of patients than formerly. There will certainly be a liaison role with other medical specialties, now that this part of a psychiatrist's contribution is at last being properly recognised.

In both of these roles, and in others besides, psychiatrists are going to have to maintain and develop their general medical skills. Those who lack these or do not keep themselves up to date will be at a disadvantage in the presence of able non-medical psychotherapists, behaviour therapists, and others who can deal very well with most of the patients referred to mental health services. These psychiatrists will simply lack the special skill that is expected in a mental health team from, for example, a social worker or an occupational therapist, over and above the psychotherapeutic skills these individuals may have. Psychiatrists of the future will need to develop skills which will give them an essential place in a community mental health team or in a hospital department. It is unlikely that the psychiatric training as it is currently designed will be sufficient.

This is not a plea for psychiatrists to retreat back into "medical model" psychiatry, with its preoccupation with diagnosis and classification. We need psychiatrists who can use a variety of explanatory models, who can think in social and interactional terms, yet who will maintain their general medical expertise.

A basic change in attitude is also needed if psychiatrists are going to integrate well into the mental health teams of the future. Most mental health professionals are aware of the importance of their own personalities in relation to their work, and it is an accepted part of their training that they will undergo some kind of self scrutiny so that their blind spots and the rougher edges of their psyches will not work to the disadvantage of their clients. This is not usual for psychiatrists and it is not even regarded as an essential part of a psychiatrist's training. This simple lack is connected with the very biological-medical view of most British psychiatrists, which enables them to believe that they are above such things; nevertheless, it isolates them from the broad current of developments in mental health services and the concept of real team work.

So, if I had to commit myself about how psychiatrists should prepare themselves for the next decade, I would say, "Keep up with your general medicine and be more open about yourselves."

This paper is based on a talk given to Avon psychiatrists in January 1987 and I am grateful to them for the ensuing discussion, although the responsibility for the ideas expressed is mine alone.

(Accepted 21 September 1987)

The increasing use of defibrillators means that victims of drowning may be defibrillated. Occasionally, direct current shocks need to be given with the patient lying on a wet metallic surface. Is this safe and would treatment be adversely affected?

There is no indication to defibrillate the victims of near drowning. Ventricular fibrillation occurs usually as a complication of coronary artery disease and this is rarely a problem in immersion victims, most of whom are young and healthy. The more common arrhythmias include nodal bradycardia, atrial fibrillation, and asystole. Ventricular fibrillation may, however, develop as a complication of hypothermia but while the myocardium is cold it will not convert electrically. Rewarming a patient with circulatory arrest is technically difficult but has been achieved by extracorporeal heating of the blood on bypass or peritoneal lavage.—MARK HARRIES, consultant physician, Harrow, Middlesex.