to this subject and includes three contributions from consultant psychiatrists and additional ones from a clinical psychologist, a psychiatric nurse and a psychiatric social worker. Positive and able members of the non-medical specialties are selected in order to present a competent image of each profession. Senior registrars are able to consider their approach to non-medical clinical colleagues and to clinical teams in the light of these contributions. In this setting the special problems of teams that straddle local authority and health authority employment can be better identified and discussed.

The core analytical content of the clinical management input deals with the issues of decision making in clinical teams and looks at alternative decision making models. The programme allows for a more in-depth consideration of alternatives and, for example, a discussion of the leadership model will concentrate upon appropriate styles of leadership in psychiatric settings. This work centres upon both diagnosis and treatment and includes consideration of the changing patterns of GP referrals. The presence of an additional session for a GP contribution to the programme is under active consideration.

**Challenges for the future**

The programme grows and changes in response to the current challenges facing psychiatry. Current challenges include:

(a) The continued transference from hospital to community is constantly changing the membership of clinical teams and networks and the pattern of clinical decision making. The interrelationship between the two is of crucial importance for psychiatrists developing new patterns of service.

(b) The new circular PL/CMO(89)1 *Medical Responsibility in NHS Hospitals and Community Services for Mentally Ill and Mentally Handicapped People*, changes the traditional view of the consultants' role outlined at the beginning of the NHS as "overall clinical responsibility" to one of "medical responsibility". Medical staff may see this change as being purely semantic but non-medical professions see it as a major change in their role and status and some have even argued that it is a move towards putting psychiatry outside the ringfence of medicine. It is therefore necessary to secure a very positive medical view of the circular and to consider working interpretations which do not undermine that ultimate medical responsibility.

(c) The resource management initiative in the NHS has so far concentrated upon surgical and related specialties and psychiatric services have been excluded. One consequence of this initiative will be to identify appropriate costs for each item of care and in the longer term will create pressures for appropriate funding as the clinical volume of work grows. Mental illness and mental handicap services have always tended to receive a block allocation within which to meet a growing volume of demand and such resource management initiatives could now be of value for psychiatry.

(d) This list would not be complete without a reference to the White Paper although the exact extent to which this influences the syllabus of future management programmes has still to be determined.

The resource management aspects of the Keele programme involve contributions from general management, financial management and from a Regional Medical Officer. These are both to provide a resource context for the study of clinical management and to create opportunities for senior registrars to question these officers about the management and development of their service. Crucially, they consider medical advisory committee machinery, and the planning process and the opportunities for psychiatrists to make effective contributions to that planning process.

## *The context for management education in psychiatry*

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From an author who makes a major part of his living from providing management education for doctors[1] the reader is entitled to a justification for the claim that such education is necessary at all. That is the purpose of this short note, which also serves to provide a context for Professor Dyson's and Mr Joyce's remarks about the content of management education in psychiatry.

Before the Griffiths changes of 1984–86, it was possible to regard management education for doctors as an option. Quite simply, and with some exceptions, health service managers could be regarded as acting on doctors' behalf. Empirical research[2] into pre-Griffiths NHS managers' behaviour shows it to have been 'diplomatic' in character; rather than being the proactive, consumer-orientated, all-powerful actor found in the pages of popular management textbooks, he or she was more concerned to smooth out internal conflicts and to provide facilities for professionals to get on with their work.

No wonder then that the BMA was so alarmed at the prospect of general management:

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"... a somewhat autocratic ... manager would be appointed with significant ... powers, who would ... be able to make major decisions against the advice of the profession. It should be clearly understood that the profession would neither accept nor co-operate with any such arrangement....[3]"

In the event, such opposition has not carried over into the views of individual clinicians, and nor has the apparent threat been fulfilled, as is shown by two recent empirical studies of the impact of the Griffiths changes.[4,5] One of these is specifically related to psychiatrists, while the other is a larger and more general study. But the findings are consonant and can be summarised in the following terms.

Firstly, there is little discernible opposition in principle to the notion of general managers, and no apparent desire to return to the pre-Griffiths system of formalised consensus decision making. Secondly, however, general managers have not turned out to be all-powerful. Consultants still have substantial power to obstruct unwelcome changes, and managers' assumptive worlds are still centred on the notion that doctors should not be challenged. Thirdly, doctors do see advantages for themselves in the new arrangements. They are now clearer than before about which managers are responsible for what, and many discern quicker decision making, greater delegation and better implementation of decisions. Fourthly, and in contrast, these advantages have been at the expense of a perceived reduction in consultation with the medical profession, and some consequential bad decisions about patient care.

The Griffiths changes have, of course, coincided with increasing financial stringency in the Service, and a number of post-1982 changes may more plausibly be attributed to this changing climate than to the Griffiths initiative itself.[6] Among these are much greater awareness by doctors of the cost implications of their work, and much greater power for managers in one specific area: service closures against medical wishes, in order to avoid overspending. So the Griffiths changes have not, as the profession originally feared, produced a massive shift in medical-managerial power relationships.

Paradoxically, however, this makes management education for doctors more important than before, since it is likely that continuing financial restrictions will increase managerial influence, a trend likely to be reinforced by the proposals in *Working for Patients*. What is crucial, therefore, is that managerial and medical concepts of what represents 'good performance' in medicine and health care are as far as possible integrated. In addition, micro-level managerial skills, employed for the patient's benefit, will become increasingly important as the British health care system becomes more fragmented across a multiplicity of agencies and institutions.

Management education, at all levels of the medical profession, would be one vehicle for the achievement of these objectives.

## Notes and references

[1]Details of the MBA (Health Services) Programme, and short courses at Leeds and on health authority premises are available from the author at 71–75 Clarendon Road, Leeds LS2 9PL.

[2]Harrison, S. (1988) *Managing the NHS: Shifting the Frontier?* London: Chapman & Hall, chapter 3.

[3]Social Services Committee, First report; *Session 1983–84: Griffiths NHS Management Inquiry Report*, London: House of Commons Paper no. 209, p. 2.

[4]Harrison, S. & Schulz, R. (1989) Impact of the Griffiths Reforms of NHS Management: The views of psychiatrists, *Health Services Management Research*, Vol. 1, no. 3.

[5]—, Hunter, D. J., Marnoch, G. & Pollitt, C. J. (1989) General management and medical autonomy in the National Health Service, *Health Services Management Research*, Vol. 2, no. 1.

[6]Pollitt, C. J., Harrison, S., Hunter, D. J. & Marnoch, G. (1988) The reluctant managers: clinicians and budgets in the National Health Service, *Financial Accountability and Management*, Vol. 4, no. 3.

## Management training in psychiatric practice

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If I take the basic learning need level, then what all psychiatrists need to acquire during the time that they are registrars and senior registrars is a certain hard knowledge and a number of skills. The hard knowledge relates to understanding the organisation in which they work. To understand this they need insights into the different disciplines, not just the experience of referring a patient to a psychologist or talking to a ward nurse, but a real insight into the background of these different disciplines, what their current world view is and what their real aspirations are. They need an insight into industrial relations, an insight into the tenets of personal management and an awareness of the local political scene – by that I mean both local politicians and Health Authority politics (DHSS, Region and District). They also need information about voluntary organisations.

Alongside this is some managerial skills training. There is also a view which is quite inhibiting – that management is what happens between a line manager and his subordinate; this is a myth which must be firmly scotched. A consultant having contact with a clinical nurse specialist, with a ward manager, with a staff nurse, or with a psychologist of the clinical