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*The Nodder Report—A Scottish Psychiatrist Reacts**

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Among reports from committees and working parties, some are crisp and stimulating, while others, the majority unfortunately, are dull and sedative. The Nodder Report falls into the latter category which is a pity because some parts of it are worth reading. It is neither as good nor as useful as it should be because it fails to tackle the problem as fully and as vigorously as required. The working party have avoided difficult but essential problems such as the difficult patient, the patient concerned in criminal proceedings, the role of the consultant psychiatrist, the role of other doctors and the role of the nursing officer. They have grasped the tulips and tiptoed through the nettles.

The first disappointment, already mentioned, is the deliberate side-stepping of the problem of the difficult patient. The working group should have tackled this, because any system which does not cope with it effectively is valueless. The excuses they give for avoiding it are not good enough; they should have made time available by dropping other things if necessary, and they should have obtained the appropriate members if they did not have them.

The discussion of the management of psychiatric services as a whole is so involved with the scene in England and Wales that much of it is irrelevant to Scotland.

It is not the fault of the working group that the medical member of a management team has to be an elected chairman of a Division of Psychiatry, but there is no reason why they should not have commented on the fact that, in management terms, he will always be an amateur among professionals, and possibly a pigeon among the cats, being the only member with no contractual obligation to make the system work. In Scotland, of course, Physician Superintendents still exist—one cannot say flourish—and any Scottish system must take account of this.

This same problem crops up in connection with management within the hospital, and although there is rather more mention of the medical profession here than elsewhere it is inadequate and misleading. The abolition of the post of Medical Superintendent rates a mention, but not that more important change, the introduction to the mental hospital of the 'consultants' system on the pattern of general hospitals. This happened when the Health Service came in and long before the superintendents in England disappeared. Consultants in mental hospitals now had not only substantial responsibilities outside the hospital but full clinical responsibility inside, with the possibility, for good or ill, of different treatment regimes existing within the one hospital. In a sense, the mental hospital began to cease to be a unit, and it is this process which has perhaps gone too far and which this report seeks to reverse to some extent. The working group should have looked much more closely at the role of the consultant and especially at his responsibility. It is not enough to say that 'the diagnosis and prescription of medical treatment' is the responsibility of the consultant without saying what is meant by 'medical'. In psychiatric terms it means everything that happens to the patient of a therapeutic nature, but this is obviously not what the report means. In effect, it states that the patient's individual therapeutic programme is not the consultant's responsibility and they lay this on the multidisciplinary team. I doubt if this would hold up in law. Where the report touches on the consultant's legal responsibility, it discusses entirely the wrong issue. It is not the question of the negligence of other people that need worry the consultant, it is the question of his responsibility for what he agrees to, or allows to happen. Can he allow other people to outvote him in a team discussion and allow a programme he disapproves of to proceed? If he cannot change the programme, has he not a duty to discharge the patient from a situation he considers unhelpful or even harmful? If he does not have both the power and the

*In March 1977, the Secretary of State for Social Services set up a Working Group, multidisciplinary in composition and chaired latterly by Mr T. E. Nodder, Deputy Secretary in the department. Its terms of reference were: 'To examine the main problems arising from recent mental hospital enquiry reports and in particular the organizational and management problems of mental illness hospitals and units, in relation both to the new National Health Service structure and to the development of District Services; to examine in relation to mental handicap services those problems and solutions common to mental illness and mental handicap; and to make recommendations.'

This article is based on a paper read to a Multidisciplinary Symposium organized by Greater Glasgow Health Board at Gartloch Hospital on 11 November 1980.

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responsibility, is there any point in having consultants at all? They are very expensive and the Health Service ought to get its money's worth or do without them. Of course, the consultant needs a team of professional advisers and helpers, including other doctors, to enable him to function, but this is clearly not what the working group means by a multidisciplinary team. Their concept of the team diminishes the status of the consultant, and in this setting they do not even mention the role of non-consultant doctors. Earlier in the report, they pay lip-service to the need to attract more and better doctors into psychiatry, but the rest of the report is a recipe for disaster in that respect.

The problem of the doctors will not go away, and it should have been looked at searchingly even if no solutions could be offered. All doctors are not consultants, and consultants are not just doctors. A medical qualification is only a small part of what a consultant needs, and he is trained and appointed to carry out many tasks which are not 'medical' in the narrow sense. Consultants tend to be appointed at about the age of 35 and work until 65. The average consultant, therefore, is aged 50 and has been studying, training, and gaining experience for 33 years. Is any other profession in a position to contribute to a ward multidisciplinary team members of similar seniority? The consultant can and frequently does delegate his authority to others; but, as the report rightly points out, in respect of management responsibility cannot be delegated and the consultant cannot therefore become an equal part of a multidisciplinary team. Perhaps, then, we should dispense with consultants. Doctors do not need to operate in a consultant capacity. Many do not do so within the hospital service and are, indeed 'handmaidens of the doctor' to a degree that would really give other professionals something to complain about. Outside hospital, doctors manage to function happily in a purely advisory capacity in many sorts of situations with neither the authority nor the responsibility of the consultant. This arrangement could be made to happen inside hospitals, but until it does there is an insuperable problem. If it did happen, there might be a significant change in the type of doctor attracted to such work with unpredictable and far reaching effects.

Doctors work in the Health Service on a different footing from other professionals. Even the newly qualified houseman is personally responsible for his work in a way that protects the employing authority; as far as I know, no other professional has to carry his own insurance against legal action as a condition of his continued employment. The Health Authority or Board, which has to carry the full responsibility for the actions of other professionals, might not be keen to delegate its authority to non-medical staff in the way it currently does to consultants.

My objection to multidisciplinary teams is not that they are multidisciplinary—it is that they are teams. All patients, but especially psychiatric patients, need to have an individual to whom they can appeal or complain when things are going wrong. This does not mean that they cannot relate therapeutically with a team, but there are certain situations which require one person to be answerable 24 hours a day, 7 days a week, to the patient, to his relatives, or to outside authorities for what is happening to him. That person must also be identifiable in years to come in cases where trouble arises long after the events which may be casual; the report ignores the very real difficulty of establishing the identity of the multidisciplinary team even in the short-term. Whilst there is a role, therefore, for multidisciplinary teams in management at hospital level and above, ward management is too near patient care for this arrangement, especially in view of the unavoidable discrepancies between ward team members in regard to seniority within their own discipline, the area of responsibility outwith the ward, the continuity of their responsibility for patient care, and the length of the time each is likely to serve on the team.

When we turn to the chapter on Nursing, we find the real reason for the report's enthusiasm for the multidisciplinary team: it has nothing else to offer the nursing profession. This is the most disappointing aspect of the report, and the nurses are fobbed off with a second-rate arrangement in which the Charge Nurse will be the star, and there is no real elevation of the nurse, only an apparent elevation by lowering the status of the psychiatrist. What psychiatric hospitals need is a genuine role for the consultant nurse, which the nursing profession has promised but never delivered. The report repeats what we all know about the role of the Nursing Officer, but misses the opportunity of saying that this has to be the really important level in nursing if the profession is to achieve anything like equal status with fellow professions such as medicine, clinical psychology, and social work. We must have a nurse who is involved in patient care but who has responsibility above, but including, ward level. Such a nurse should be able to take full and continuing responsibility for certain patients, and there is no reason why this should not happen in the long-term wards of the psychiatric hospital where the nursing contribution is so clearly predominant. Psychiatric nurses have been able to leave the Health Service and accept the responsibility for caring for people in homes run by local authority. Why not do the same job in hospital? Social workers and psychologists are prepared to take full responsibility for their clients; nurses should be willing and able to do the same. Of course it means harder work and longer hours, of course it means more training and more anxiety, of course it may mean taking out insurance to keep the Health Authority or Board happy, of course it will mean giving up silly Nurse of the Year competitions. But equality has to be both earned and paid for; it cannot be achieved by hanging on to other people's coat-tails.

These changes would make way for a new form of partnership between medicine and nursing in the psychiatric hospital with some sections under the clinical control of psychiatrists and others under that of consultant nurses whose responsibilities would also extend into the community through rehabilitation programmes. This arrangement would not only give psychiatric nursing a new future but might solve some of the problems of the care of the long-term patient.

I would advise anyone to read this report with caution, partly because it has not been written with Scotland in mind, and partly because its conclusions are based on opinion rather than on fact and may not prove to be sound. Although it may influence psychiatric services for the better, I doubt if it will help to solve the problems of psychiatric hospital management, and it could conceivably make matters worse. It is, unfortunately, possible to break eggs without making an omelette.

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