Admit and double the dose.

I was appointed as a General Adult Psychiatrist which meant that, along with colleagues, being responsible for a catchment area. This arrangement has significant advantages with regards to clinical responsibility and continuity of care which I believe serves the patient well.

When I started at Wexham Park Hospital, I was attracted to the philosophy of Psychiatry being integrated within a general hospital. In addition, we had a substantial number of in-patient beds and a comprehensive day patient service. The therapeutic activities of the in-patient and day patient services were integrated which enabled a seamless transition for the patients. In addition, vulnerable patients were encouraged to come along on a relatively long term basis; in the day patient service, wise and senior nursing staff were able to support and quietly monitor progress. Community teams were developing with realistic objectives and appropriate back-up.

I was extremely fortunate in having supportive colleagues and excellent junior staff and between us, I felt we provided a very good service; urgent cases were seen within a week and emergency admissions arranged on the same day. We could also offer respite care and planned admissions. However, psychotherapy was in short supply and we did not really have sufficient resources to offer a comprehensive liaison service to the general hospital. But there is always a problem about appropriate reach of acute Psychiatry. These days the response a referral can often be “we are not paid to provide that service”. Don’t ask me what the phrase “severe and enduring mental illness” means. Does it only cover some aspects of Schizophrenia and Bi-polar disorder? If so, what about the rest?

Catchment area services are not resourced to handle a number of specialist areas such as Anorexia Nervosa, Forensic patients or those requiring locked facilities. Patients with addictions requiring rehab are not well served by acute admission wards either. One of the long term problems for a General Adult Psychiatrist is that specialist tertiary services are prone to ‘cherry pick’ individuals they want to take on. I recall one particular problematic patient who I referred on to a service and the report that came back was that she was too difficult to help and would ruin their outcome figures; I should have kept the letter. As a result, this patient stayed on an acute general ward for a good number of months but in the end, she did do well.

Responsibility without the resources becomes an extremely potent cause of stress and burnout. In the end, risk management remains with the Consultant Psychiatrist; understandably, I remain keen on taking a precautionary approach. Some years ago, one of my children, who was very young at the time, said that he could offer to answer the phone because he knew what to say, as invariably, my advice was to ‘admit and double the dose’. In fact, as a universal mantra, it is probably pretty good.

In my opinion, difficulties with recruitment of senior staff and changes in philosophy have not served the image of Psychiatry or patients well. There is now a functional model where different teams take on aspects of the care. The notion of continuity of care does not exist now. In addition, resources have been ferociously cut back; for example, there is no longer a psychiatric unit at Wexham Park Hospital or in fact any Psychiatric in-patient bed at all in East Berkshire.

Obviously, I still greatly enjoy Psychiatry but the constant erosion of resources, the increase in pointless bureaucracy and constant reorganisation meant that, like many people in the health service, I was

pleased to retire, although that word is somewhat misleading and I think ‘resign’ is a more appropriate reflection of sentiment I had at the time.

A common story.

Dr Andrew Macaulay.
March 2020.