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Guest Editorial

Taking back control: maintaining professional autonomy as psychiatrists

Robert Howard

Summary

Resource restrictions and changes to the ways in which psychiatrists are managed threaten professional autonomy and motivation. With examples from English National Health Service practice, maintaining knowledge and expertise, involvement in education and training, supporting research delivery and developing active followership skills represent transferable and realistic strategies that can improve psychiatrists' autonomy wherever they work.

Keywords

Mastery; purpose; expertise; training; followership.

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Autonomy and maintaining a sense of mastery and purpose in our work are important professional motivators for doctors, and are associated with higher levels of work satisfaction and lower levels of burnout and intention to leave work.[1–3] However, the ability of psychiatrists to influence the care environments in which they work has declined, and they have increasingly come to feel they are perceived as little more than units of productivity, working within services where it is difficult to deliver safe and therapeutic care because those services are progressively inadequately resourced.

Recent decades have seen a progressive diminution of the joy taken by physicians from most medical specialties from their clinical practice, with only 36% of US physicians reporting high levels of professional fulfilment.[4] Neurologists, emergency medicine and general internal medicine physicians are three times more likely to suffer from burnout compared with other medical specialties,[5] with mean burnout rates, as defined by the Maslach Burnout Inventory, of 65.9% in meta-analyses of studies of neurologists from China, the USA and Brazil.[6] Fewer data are available from psychiatrists but, in a survey of morale in the English mental healthcare workforce, although staff reported overall satisfaction with their work, 49% working on acute general wards and 60% of those in community mental health teams met threshold scores for burnout.[7] Self-reported autonomy in carrying out job roles was strongly associated with both lower emotional strain and higher positive work engagement, so that every one-point increase in rating of control was associated with a 0.38 standard deviation increase in positive work engagement.[7]

Waddimba et al have defined physician autonomy as 'the free volition to use individual perspectives and exercise personal choices to perform clinical tasks without undue pressure, while staying accountable'.[8] For consultant psychiatrists, autonomy will involve the ability to manage their own practice and schedule while for those still within postgraduate training it will rather reflect decision-making power in patient care under supervision. Commissioned by the General Medical Council in 2023, a deep dive into workplace autonomy reported that 60% of doctors agreed with the following statement: 'I have enough autonomy in my role'. Working with unsupportive or unavailable colleagues and service resource restrictions emerged as systemic barriers to autonomy, with respondents who considered they had sufficient autonomy in their role feeling supported by immediate and senior colleagues, as well as by non-clinical management, and having good access to development and learning opportunities.

The Royal College of Psychiatrists' Retention Charter requires that mental health services value the identity of psychiatrists as clinical leaders and experts, and include their voice in multiprofessional structures, organisational decision-making and the design of clinical services. Participation in any of these activities will affirm professional autonomy and can be supported by employers looking for evidenced ways to improve morale and retention. Specifically, the Charter asks that 'Leadership functions, medical management, educational roles, mentoring, quality improvement, research activity and other important work that is not directly patient facing is formally recognised in job plans with appropriate remuneration, support and resources to do this'. As a positive response to this, individual psychiatrists should develop existing activities, or explore new areas of interest, to build islands of significant professional autonomy into their weekly timetable.

Knowledge is the foundation of psychiatric practice, and use of the processes involved in continuing professional development to improve competence and the depth and breadth of knowledge is an important support to professional autonomy. Taking time to understand the research base that supports an area of practice, through personal study or attending a course or conference, and maintaining this knowledge through reflection on your practice outcomes, is an obvious first step to enhancing personal professional autonomy. Rather than measuring your engagement in continuing professional development by the hours of activities you attend, choose goals that involve a mastery of the evidence within a specific area and set a date to present this to the members of your peer group. Nothing is more mentally clarifying and consolidating than the preparation and delivery of material to colleagues.

Multiple educational roles are open to consultant psychiatrists. Those who are not already clinical or educational supervisors are missing the rewards of interaction with the current cohorts of outstanding resident doctors who have joined our speciality and will soon become our immediate consultant colleagues if we can retain them. Psychiatry resident supervision has long been viewed with envy and awe by those outside our speciality, and offers autonomy-enhancing opportunities to influence and guide developmental progress through postgraduate training, as well as access for supervisors to the knowledge and thinking of (generally) younger colleagues. Consultant vacancies and pressure from job plans have contributed to shortages of supervisors across National Health Service (NHS) trusts, and any offer to take on these roles is likely to be welcomed. High-quality training and preparation for

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these roles is easily accessed. Most of us will already, albeit in unofficial and unrecognised ways, be acting as mentors and coaches or be in receipt of coaching and mentoring ourselves. These roles require less commitment within the job plan than educational or clinical supervision, and the Royal College of Psychiatrists can signpost those who are interested in receiving training and support to available resources, including supervision.

For consultants working in the NHS, involvement in research is more straightforward than many will appreciate and offers opportunities to develop new skills and further a deep and autonomy-confirming understanding of the evidence that underpins practice. However, the success of any clinician's involvement in research depends upon realistic goal setting and the availability of adequate training and supervision. Most locally conducted quality improvement studies fail to either complete data collection or deliver robust conclusions because of a lack of these ingredients, and can provide a disheartening experience for colleagues who want to become involved in research. Providing support to ongoing research projects – for example, through contributing to recruitment or assessment of clinical trial participants within your Trust – is likely to be a more successful starting point and will be welcomed (and, sometimes, even funded) by local research and development departments. As a practical way to help clinicians explore and advance this, the National Institute of Health Research (NIHR) Associate Principal Investigator Scheme provides structured training in research while working alongside an experienced local principal investigator, who acts as a formal mentor while demonstrating, through their example, what it means to be a principal investigator on a multicentre study. This will usually be a multicentre clinical trial that has been adopted onto the NIHR portfolio, and the opportunity for supported experiential learning about research culture and delivery in the NHS, and involvement in the life of a study with 'real-world' relevance to the practice of psychiatry leads to the development of confident new principal investigators who can take on their own studies and a share in the achievements of psychiatry as an academic speciality that is constantly questioning, testing and improving what we can offer to our patients.

Finally, while formal involvement in medical management and leadership may offer understanding of the challenges and threats to professional autonomy that can be generated by restrictions of resource to the services in which psychiatrists work, few of us will take on such roles. At a time of under-investment in public services, colleagues in leadership and management roles may themselves experience only limited professional autonomy, as their decisions become increasingly dictated by a lack of resources and they risk personal association with the consequences of underlying austerity in the eyes of their colleagues. All psychiatrists provide leadership to the members of their multidisciplinary clinical teams, and using our training and knowledge to do so effectively is strongly affirming of our professional autonomy. However, we all have capacity to shape and help to define the wider leadership of the organisations within which we work if we become proactive followers. Followership (a quality of leadership shown by individuals who carry responsibility without formally recognised authority)[9] involves commitment to actively advancing the aims of your organisation and its leadership. This does not equate to blind acceptance, and requires that followers work to understand the environment within which important decisions are being made and, where they can, influence and support leadership to make wise and equitable decisions. A measure of good clinical leadership and management is that it encourages and responds to constructive followership, and we can build our own professional autonomy through a sense of learned helpfulness that comes with deployment of these skills.

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