

medical doctors' expertise. The Royal College of Psychiatrists should take this issue up with its members.

- 1 Craddock N, Antebi D, Attenburrow M-J, Bailey A, Carson A, Cowen P, Craddock B, Eagles J, Ebmeier K, Farmer A, Fazel S, Ferrier N, Geddes J, Goodwin G, Harrison P, Hawton K, Hunter S, Jacoby R, Jones I, Keedwell P, Kerr M, Mackin P, McGuffin P, MacIntyre DJ, McConville P, Mountain D, O'Donovan MC, Owen MJ, Oyeboode F, Phillips M, Price J, Shah P, Smith DJ, Walters J, Woodruff P, Young A, Zammit S. Wake-up call for British psychiatry. *Br J Psychiatry* 2008; **193**: 6–9.

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doi: 10.1192/bjp.193.6.510a

Craddock *et al*'s 'Wake up call for British Psychiatry'¹ is a timely reminder of the need for our profession to reassert its essential qualities, particularly in view of the current low recruitment rate into psychiatry from UK graduates. The Psychiatric Trainees' Committee (PTC) agrees with the observation that the medical component of psychiatry is being devalued. Indeed, this is apparent in many of the recent changes associated with psychiatric training.

The European Working Time Directive has in part contributed to reduced exposure to emergency psychiatry. This has resulted in a reduction in the recognition and management of biomedical aspects which are often key in acute psychiatric presentations. This has been exacerbated by financially stretched trusts gradually reducing the out-of-hours contribution from trainee psychiatrists in favour of cheaper alternatives.

New Ways of Working remains contentious. Specific consideration is required to ensure that postgraduate training adapts both in substance and in delivery to ensure that future psychiatrists have the necessary skills to fulfil the changing role of a consultant. Trainees are increasingly anxious that the rapid evolution of New Ways of Working has become a driver for preventing essential continued expansion in the numbers of consultant psychiatrists. Indeed, there is a growing political atmosphere suggesting that consultants will be needed less abundantly than at present.² The PTC firmly believes that the introduction of a sub-consultant grade will diminish the endpoint of training, further devalue the profession and not serve the needs of patients.

These issues, alongside the changes resulting from Modernising Medical Careers and the significant stresses of the Medical Training Application Service, are contributing to a cohort of trainees who perceive that they are not in a valued profession.

We believe that the new competency-based framework of psychiatric training, if robustly quality-assured, offers a solid opportunity to reassert the training needs of future psychiatrists, especially in regard to their unique medical expertise in the assessment and treatment of mental disorders. However, the current changes within mental health services threaten to undervalue our role as medical specialists. This is likely to further alienate medical undergraduates and compound the current recruitment crisis.

Urgent work needs to be done by our profession to re-engage with both the government and the public as a whole to ensure that the essential contribution psychiatrists make in providing a high-quality mental health service to our patients is not further devalued.

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Walters J, Woodruff P, Young A, Zammit S. Wake-up call for British psychiatry. *Br J Psychiatry* 2008; **193**: 6–9.

- 2 NHS Employers. The future of the medical workforce (<http://www.nhsemployers.org/workforce/workforce-2193.cfm>). NHS Employers, 2007.

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doi: 10.1192/bjp.193.6.511

One cheer at least for Craddock *et al*'s¹ polemic. Critical of the de-medicalisation and role-diffusion which they see as characterising contemporary British psychiatry, they argue that those with severe mental illnesses are best served by an initial consultation with a professional with the diagnostic skills of the consultant psychiatrist. Without such an intervention, they claim, the patient is likely to be psychopharmacologically disadvantaged, possible physical disorders may be overlooked and scientific advances not brought to bear on their illness.

Nevertheless a neutral observer might be tempted to see their 'wake-up call' as a tendentious attempt to regain hegemony by the psychiatric establishment. Their *ad hominem* 'thought experiment' – inviting readers to ask themselves whether they would be happy for 'a member of their family' to be cared for under the 'distributed responsibility' model – seems unworthy of such illustrious academics, a hostage to the possibility that many will take the contrary view. The two absent cheers are for the missing psychosocial components of Mayer's bio-psychosocial triad, first proposed a century ago, midway between Reil² and Craddock *et al*. Indeed, that lack exemplifies the narrowness of vision which has arguably led to the very crisis which they bemoan. Nowhere do the authors consider the social forces driving de-professionalisation: the need to contain burgeoning healthcare budgets; flattening of social hierarchies, with leadership to be earned rather than role-bestowed; and technology-driven fragmentation of care.

Understanding these processes, and knowing how to work productively with the rivalries and distortions they create, is as essential to the psychiatrist's repertoire as the latest psychopharmacology update. Nor are these issues confined to psychiatry, not excluding the cardiology model so dear to their hearts. The good general physician who takes an overview of a whole patient, including psychological aspects, and is not merely a technical expert in the minutiae of a malfunctioning organ, is as rare a species as the putative 'superlative' psychiatrist.

Craddock *et al*'s view of the science relevant to psychiatry is similarly limited, confining itself to molecular biology and neuroscience. There is no mention of recent advances in developmental psychopathology³ which illuminate the psychological deficits of psychiatric illness, and the interpersonal skills needed by therapists to ameliorate them, or of psychotherapy process–outcome research which is beginning to tell us which kinds of therapy work best for which kinds of condition and personality. Waking up is the instant when dreams momentarily enter consciousness. Behind their grumpy growling, Craddock *et al*'s reverie sounds like regressive nostalgia for an idealised past with which it is hard not to feel sympathetic, but is devoid of plans – as opposed to wishes – for the future.

A more hopeful straw in the wind is the recent Royal Colleges of Psychiatry and General Practitioners joint document on psychological therapies.⁴ This argues the case for structured training in psychosocial skills for psychiatrists and general practitioners. Craddock *et al* might consider the possibility that a psychotherapeutically informed psychiatrist – whose abilities

include dream interpretation – is more likely to regain a key role in the surely-here-to-stay multidisciplinary team than one whose expertise is narrowly confined to ‘excellence’ in prescribing, desirable though that no doubt is.

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- 2 Reil J, Hoffbauer J. *Beytrage zur Beforderung einer Kurmethode auf psychischem Wege* [Contributions to the Advancement of a Treatment Method by Psychic Ways]. Curt’sche Buchhandlung, 1808.
- 3 Mayes L, Fonagy P, Target M (eds). *Developmental Science and Psychoanalysis*. Karnac, 2007.
- 4 Royal College of Psychiatrists & Royal College of General Practitioners. *Psychological Therapies in Psychiatry and Primary Care* (College Report CR151). Royal College of Psychiatrists, 2008.

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doi: 10.1192/bjp.193.6.511a

Craddock *et al*¹ make some interesting points about the role of the psychiatrist. It is unashamedly made from a psychiatrist’s perspective.

We would like to comment from a primary care perspective, since many of the issues raised have a significant bearing on the way primary care works currently and how it may work in the future.

The authors make the point that ‘psychiatry is a medical speciality’ and that general practitioners should have the opportunity to refer patients for an opinion when they are unclear about the diagnosis or treatment. Sadly, in our experience, this rarely happens, as patients who have a mood disorder such as depression or anxiety are often told that they do not fulfil the criteria for referral (understood by the patient to mean that they are not ‘ill enough’) to see a psychiatrist. It is a rare occurrence where a psychiatrist will intervene in the administrative chore of ‘bouncing the patient’ back to the GP, so that the patient does benefit from their opinion. Such referrals are often pejoratively labelled as inappropriate, implying a lack of competence by the referrer.

This behaviour, of screening out people with certain conditions, is justified on the grounds that psychiatrists should concentrate on the most ill, that is the psychoses, and they quote the National Service Framework for Mental Health as supporting this stance. No other medical speciality diverts patients away from a medical opinion in the same way. It is a sad testament to both primary and secondary care clinicians that the person who was able to negotiate an improved level of care for people with a significant mental illness such as depression or anxiety was an economist, making an economic argument at the highest level of government.

The authors also make the case that they should be responsible for managing the physical healthcare needs of the people for whom they care. They are, according to the authors, first and foremost highly trained doctors. What has stopped psychiatrists providing this care in the past? Are the authors really making the case that they should manage not only the psychiatric needs of a person with schizophrenia, but also that person’s diabetes, hypertension, obesity and osteoarthritis? Surely not. Readers were offered a thought experiment; we offer another thought experiment to the authors: if you had diabetes, hypertension, obesity

and osteoarthritis, would you want these conditions managed by a psychiatrist, or a GP?

If there is a real concern that psychiatrists no longer have the opportunity to practise the speciality in which they trained, then they should do something about it. The National Service Framework for Mental Health is coming to an end – so the restrictions on who psychiatrists will see should also come to an end. If psychiatrists wish to behave as other medical consultants, then they should see the referrals made to their teams – as team leaders it is in their gift to do so. It may well be that some form of screening may be necessary, but do so based on patient need, not on the basis of a diagnosis.

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doi: 10.1192/bjp.193.6.512

There are a number of key issues which those who have criticised the ‘Wake-up call for British psychiatry’¹ have failed to address.

- (a) In order that any illness be treated, proper assessment and diagnosis is necessary. Is there definitive evidence that complex problems such as very early psychotic illness (at-risk mental states) or type II bipolar disorder can be properly identified by non-medical staff without specific training? Is there a possibility that cases may be missed – and how big is this risk?
- (b) How certain can any doctor – or indeed any person – be that they can assess ‘service users’ appropriately based only on the reported assessment of others? This is different from asking other respected professionals for their considered opinion in a multidisciplinary meeting.
- (c) Why is psychiatry the only medical speciality where many seem to feel that we can accept ‘patient choice’ to take or not take medication with entire equanimity, even though we know that antipsychotic medication and antidepressants do actually help treat symptoms . . . and then why do we suddenly become concerned when tragedy happens because of non-concordance with medication?
- (d) Why do we in the UK expect other professions to deliver all psychological interventions, while we simply seem to provide biological treatment? Why do we not provide psychotherapy as well as medication as many of our colleagues in Europe do? Should there not be one standard for how psychiatric help is delivered across the continent of Europe . . . and should this not obviously be holistic?
- (e) Having been a GP for many years before going into psychiatry, I would ask, why are psychiatrists and their teams happy to dispense with the common courtesy of expecting the person addressed to answer a GP referral; in what other profession is ‘sending the referral back because it is inappropriate’ after a brief discussion in a multidisciplinary meeting considered an appropriate response? When this happens, is it not the service user who suffers because their problem is not dealt with?