The dispensable psychiatrist

John Kellett

Changes in the organisation and delivery of psychiatric services are likely to increase the stigma of mental illness, reduce the role of the psychiatrist, and inhibit recruitment of the best medical students. The value of close integration with the district general hospital and medical school is stressed. The future of psychiatry will be in doubt if this is ignored.

Thirty years ago a major concern of the profession was to remove stigma from our patients. This involved improving the skills and the reputation of the psychiatrist held by the general public and his medical colleagues. Most of these objectives could be met by taking the patient out of the old asylum and setting up out- and in-patient units in the district general hospital (DGH) (Kellett & Mezey, 1970). Psychiatrists took an interest in psychosomatic conditions, were quick to exploit advances in general medicine, and were regular participants in medical conferences. Patients were happy to be seen in the general hospital and were often unaware that they were seeing the dreaded psychiatrist. Those presenting at other clinics took the transfer with ease, and those whose mental symptoms were due to physical disease had the investigations on tap. Major mental illness took its proper place alongside other illness, while minor conditions were often helped by self-help groups no longer ashamed to identify themselves as having mental illness.

The current policy of splitting psychiatric trusts from trusts for the physically ill, amply aided by a well-intentioned move to the community (incorporating the multi-disciplinary team or MDT), is rapidly reversing these hard-fought changes. The DGH is delighted to reclaim out-patient resources which can be given to newer medical specialities, while the mental health trust sets up clinics in its community bases, well separated from pathology laboratories. These are quickly identified by the community as clinics for the despised mentally ill. In-patient beds are moved off the DGH site for ease of administration and reduction in cost. The opportunities for stigmatisation increase.

The argument for keeping psychiatry in the DGH has nothing to do with any debate over the medical model. While conditions like psychotic depression benefit from this, social treatments are as easily applied here as anywhere. It is often easier to run a social club for isolated individuals in the local hospital. A therapeutic community is just as viable on a hospital-based ward. The values of the hospice can be as easily adopted by those looking after patients in the terminal stages of their dementia as those of the intensive care unit.

However, by removing the psychiatrist from his medical colleagues, his role is increasingly threatened. He is the most expensive member of the MDT, thereby providing a temptation to managers to cut costs by dispensing with his services. His pharmacological skills may be assumed by the general practitioner, leaving the other staff to give supportive psychotherapy. His proper role of making the diagnosis, leading and educating the team, providing a model for medical students, and conducting research, is no longer recognised. The fundholder may well seek a solution in employing his own counsellor and prescribing the now relatively safe antidepressants himself. Other professions can easily lead the team where their psychotherapeutic experience may seem to be better in tune with the needs of the other disciplines. The separation of the base from both the psychiatric centre and the DGH reduces social contact with other psychiatrists and physicians, leaving the psychiatrist as a puppet of his team. He therefore depends for his self-esteem on the support of a team where his unique contribution can be discounted.

The future of psychiatry depends crucially on recruiting the best medical students, and on research. While the role of a 'glorified social worker' may attract the general practitioner *manqué*, the majority of brighter students will wish to enter specialities seen as near the core of medicine. A speciality with no beds near the medical school, whose language is sociological rather than physiological, and whose medical interests (like dementia) are taken over by neurologists, is hardly likely to inspire. In so far that the US precedes our experience, it is interesting to note the decline in the number of US medical students wishing to specialise in psychiatry since a peak in 1988 (Sierles & Taylor, 1995).

In 1987, Creed & Goldberg drew attention to the importance of positive attitudes from consultants in encouraging housemen who had

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achieved honours in psychiatry to follow this speciality. Poor quality entrants will rapidly intensify the problem, until we return to the dichotomy of the 1920s when many were supervisors of institutions, and a very select few remained in medical schools to provide width to medical education (unless even this role is subsumed by academic general practitioners). The institutions are a consequence and cause of the stigmatisation of mental patients whom society wants to shut away. This is likely to follow the exposure of patient abuse in the community hostel, and high profile cases of crime caused by mental illness. Such isolation only increases stigma and fear.

Research flourishes with cross-fertilisation. Certainly community bases can contribute to epidemiology and drug trials, but it is more difficult to see how they can house basic biological research. Despite the growth of information technology, there is little to replace a good postgraduate library replete with current journals, experts available for advice, and postgraduates seeking higher degrees. Statistical expertise and audiovisual aids to the presentation of data depend on being part of the medical school, and are less likely if the only office available to the consultant is at the community base. The best research unites clinicians with basic scientists: a forlorn hope when they are based on different sites.

Lest the reader sees the above as the usual prediction of doom from the retiring doctor, it must be emphasised that none of these changes are inevitable. Psychiatrists still have influence over the decisions of their managers and can retard their expulsion from the DGH. A good liaison service with a rapid response is valued by most consultants who would support the continued presence of psychiatry. A charismatic leader of a community team can maintain the morale of the team and the patient. Atypical antipsychotics and muscarinic agonists will need specialist care, while electroconvulsive therapy is unlikely to pass out of the hands of the psychiatrist. GPs may employ psychiatrists on a sessional basis as a more cost-effective system than supportive psychotherapy. Psychiatric subspecialities may create a demand specific to their skills. Current psychiatrists with an enthusiasm for teaching can continue to inspire students, provided they are aware that the chemist and the cell biologist is as important a recruit to the speciality as the sociologist. The continuing enigma of schizophrenia, and the rapid progress on Alzheimer's disease, should keep biological research alive.

Good postgraduate education can bring psychiatrists together, but the further away the base the stronger must be the attraction of the programme. The Royal Society of Medicine may provide a focus for academia, at least in London, while our own College is not short of meetings. However, the less social or confident psychiatrist may well retreat to his base, and even encourage his team to project their difficulties onto his colleagues. Agoraphobia is not limited to housewives, nor paranoia to physicians.

Danger is always minimised by foreknowledge. Let us hope that psychiatry avoids the fate of chest medicine. But the danger has never been greater, not least because so many deny it.

References

CREED, F. & GOLDBERG, D. (1987) Doctor's interest in psychiatry as a career. *Medical Education*, **21**, 235–243.

KELLETT, J. M. & MEZEY, A. G. (1970). Attitudes to psychiatry in the general hospital. *British Medical Journal*, **4**, 106–108.

SIERLES, F. S. & TAYLOR, M. A. (1995) Decline of US medical student career choice in psychiatry and what to do about it. *American Journal of Psychiatry*, **152**, 1416–1426.

John Kellett, *Division of Geriatric Medicine, St George's Hospital Medical School, Cranmer Terrace, London SW17 0RE*

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