Trainees' Forum

Changes in American Psychiatry: Impressions of a UK Trainee

MICHAEL B. KING, Registrar, Maudsley Hospital, London SE5

It is clear that, at least in recent years, American psychiatry has been on the move. The past decade has seen dramatic shifts in emphasis away from the complicated, empirically derived and little validated theories of the Post-Freudians. A new, aggressive medical specialty is challenging analytical departments in medical schools and post-graduate teaching hospitals. This is most apparent on the Eastern seaboard, in States which have traditionally been more orientated to European views.

The turnabout in American psychiatry in the last fifteen years is well known to clinicians on this side of the Atlantic who are involved in research and teaching, or who at least keep abreast of current journals. How pervasive this move in the USA has become, however, is only fully revealed in the training schemes for young psychiatrists. Having recently taken part in a six-month exchange programme in Liaison Psychiatry at Johns Hopkins Hospital, Baltimore, working as a resident, a position equivalent to registrar in the United Kingdom, I have had the opportunity to observe the changes at first hand.

Just a few years ago, most departments in the country had succeeded in moving well away from the medical model. Postgraduate medical training for potential psychiatrists was reduced to a minimum. Although training remained extensively based in hospitals, the specialty was increasingly viewed by medical colleagues as less and less relevant. In fact, the principal role of doctors in psychiatry came to be questioned. Young trainees spent much time and money in self-analysis, as part of their broad analytical training, with a view to eventual office practice, usually in middle class, well-to-do locations. This has been well described by Frank, Shepherd, and others. Washington D.C. is often cited as an example. The city has the highest number of psychiatrists per head of population in the world, who until the advent of Reaganomics were encouraged by the free availability of Federal funding. It is a curious paradox, therefore, that one of the new bastions of the organic approach should arise in Baltimore, a mere thirty-seven miles away. A decade ago, teaching of psychiatry in Johns Hopkins was heavily analytical. Now the psychotherapy division is withering under the biological onslaught, and the size of the department is considerably reduced.

Residents are involved in a four-year programme, the first year of which consists of six months' medicine and six months' psychiatry. There are moves afoot to make this initial year entirely medical, or at least to broaden the medical part of it, a source of some embarrassment to teachers of psychiatry just eight to ten years after having convinced medical departments that young psychiatrists no longer required basic postgraduate medical training. The next two years, at Johns Hopkins at least, is a somewhat inflexible journey through general ward work, liaison psychiatry and out-patient clinics. The fourth and final year is spent in elective periods, some ward work, and a short three months of child psychiatry. The product is a white-coated, enthusiastic medical specialist. Ward rounds and Service rounds emphasize phenomenology, genetics and psychopharmacology. Residents are impressively fluent, if somewhat too eager, with their snappy differential diagnoses based on the multiaxial DSM III. Patients are discussed from aspects such as vegetative symptoms, neurotransmitters, and the dexamethasone suppression test, whilst some teachers from the earlier generation, and a minority of residents themselves, bemoan the loss, as they see it, of sensitivity and insight into the role of unconscious conflicts and drives.

Research is actively encouraged and many residents become involved in short projects during their training. In the main, such research lies in the fields of neurochemistry and physiology, epidemiology, and psychopharmacology; and to a lesser extent phenomenology. It could be said, at least in the biological field, that American researchers are taking a world lead. Examples at Johns Hopkins, such as the Alzheimer's Research Clinic, and the Huntington's Disease Research Project are efficient, well run units concentrating on basic issues of careful classification, diagnosis and epidemiology, with follow through, where possible, of cases to post-mortem. Ideas appear to be well thought out and projects frequently involve active co-operation between psychiatrists, neurologists and pathologists. Although researchers criticize the shortfall of funds under the current political administration, it does not begin to approach the rigours of parallel cuts in this country.

A biological emphasis in psychiatry may also result in more junior doctors entering the specialty. The low numbers of new graduates entering psychiatry in recent years (less than five per cent) is beginning to change for the better. A combination of factors, such as increasing pressure of numbers in other specialties, may well be contributory, but it leads one to speculate whether the 'remedicalization' of

psychiatry is drawing doctors who, previously, might have been reluctant to leave their medical background behind. Many trainees are appearing with interests that straddle clinical neurology and psychiatry, some of whom are acquiring American Boards examinations in both fields. This will no doubt tend to bridge what some view as a rather arbitrary division between neurology and psychiatry.

Liaison psychiatry too, has taken on a new form. The old liaison methods concentrating on 'staff-patient relationships' and the 'medical ward milieu' have given way to the growing Consultation Service. Psychiatrists no longer advise physicians how to relate to patients, but instead are becoming involved directly with the psychological accompaniments of physical illness, such as delirium and depression. Thus they are a valuable resource for medical staff in patient management. The Consultation Unit at Johns Hopkins is one of the most efficient and fast growing departments in the hospital.

Disappointments and drawbacks are inherent to fresh developments in any field of medicine, some representing unique problems, others old pitfalls in new disguise. Psychiatrists in training at prestigious institutions such as Johns Hopkins experience fierce competition and therefore, not unnaturally, wish to present themselves to their teachers in the best possible light. Although the opinions of residents are diligently sought, decisions regarding the training programme tend to be made from the top, and at times seem somewhat authoritarian. In the fourth year of their training, as in most other medical and surgical specialties, one or two Chief residents are selected from amongst them to act as representatives liaising between junior staff and the heads of departments. These positions carry prestige and are an obvious recommendation in the competition of later careers. The grounds on which the selections are made are never detailed. Those individuals who meet the conventional requirements of the academic heads of staff are generally the ones chosen. It was apparent, however, that Chief residents tended to identify with the Administration, rather than with their colleagues. This sometimes resulted in divided loyalties, particularly in bodies such as the Residents Associations, where complaints or concerns about the training were frequently hammered out at junior level.

A further drawback is the conformity of trainees. Tight, carefully structured rotations tend to produce a quality controlled product with little room left for eccentricity. This is offset by the swing away from analytical teaching where trainees now have a greater chance to engage in their own research. In this field original ideas do receive a sympathetic hearing, but the time available is short and subject to the demands of clinical work.

Even though most departments continue to support the psychotherapies, this is often of secondary importance. Residents are encouraged, particularly in their out-patient attachments, to take on patients in long-term therapy with back-up supervision. Lunches are provided at weekly supervision sessions to ensure attendance.

Self-analysis by doctors in training is now viewed, in Johns Hopkins at least, with diffidence. The Professorial Unit insists that if residents do undertake any form of training analysis, it must be done out of hospital hours, a significant shift from earlier days. American trainees do, however, continue to receive financial incentives to pursue this aim by way of taxation rebates, or the somewhat dubious method of assigning themselves an appropriate psychiatric diagnosis to enable them to make an insurance claim. This latter practice would seem more than a little risky in a country which still views any official record of psychiatric disability with distaste.

All this has not come about without comment by the more analytically based teaching institutions. Centres such as Johns Hopkins, Massachussetts General and others of similar persuasion, are seen as having thrown out the baby and kept the bathwater. Their Psychiatric Departments are viewed by some as places of clinical investigation and physical treatments with little or no psychotherapeutic intervention. This, however, is the extreme position. Often a consensus is sought by exchange of teaching and even training posts to facilitate a degree of eclecticism. It was, therefore, of some interest to the writer to observe the reaction of doctors at Johns Hopkins to a suggestion by a neighbouring analytical hospital in Baltimore that closer ties, even amalgamation, between their training scheme and that of Hopkins might be beneficial to both. The idea was not received favourably at Hopkins, where most residents could discern no real benefit. It seemed that they were not sufficiently concerned by the diminishing numbers of their psychotherapy tutors to grasp at this outside opportunity. It was lack of interest, rather than opposition to the proposal *per se*, that was most striking. The explanation may lie in the increasing polarization of trainees into the various training schemes that reflect their interests. Prospective psychiatric trainees increasingly shop around the country assessing teaching centres on an unofficial 'biological' versus 'dynamic' rating scale, before applying for positions.

In contrast, Johns Hopkins has a particularly open policy toward the training of clinical psychologists in psychiatry. These postgraduate trainees are incorporated at all levels in the psychiatric rotation, including the markedly medical based liaison psychiatry. Though they do not accept full clinical responsibility, cannot prescribe drugs, and remain attached to their own department of psychology, they present an interesting anomaly. At one level the Department of Psychiatry views its residents as medical doctors unique in their training and abilities, whilst at another it considers them interchangeable with non-medical psychology graduates.

To sidetrack a little: no account of recent trends in American psychiatric training programmes would be complete without mention of social changes which have had a profound influence, quite apart from the analytical-biological debate. Johns Hopkins residents have one testing ground

more rigorous than most, which involves their work in the psychiatric emergency clinic. Emergency rooms, both psychiatric and general, throughout American hospitals reflect a societal trend, most marked in the US, of rapidly accelerating figures for crime, especially violent crime. It is certainly true that the general incidence of crime is rising in most Western countries, but all fall far short of America, where the increase in violence is well documented to be approaching an exponential curve. This inevitably produces a social tension which rests uncomfortably in large hospitals. Johns Hopkins maintains a rigid security screen for all persons entering the hospital buildings and uniformed officers are carefully visible. Residents face violent patients, often under the influence of alcohol or drugs, and not uncommonly armed, to a much greater degree than their contemporaries in the UK.

This emergency work is compounded by another societal trend, that of successive Health Administration policies in recent years to empty long-stay psychiatric hospitals. There is recent, though admittedly controversial, evidence that many so-called street people, that is people adrift in cities with no fixed abode, are chronically mentally ill. Such patients almost always lack health insurance, a fact which institutions like Hopkins finds embarrassing, if not a confounded nuisance. Residents tend to expend much time and effort despatching such individuals to local State hospitals, which are already so overcrowded that some will not easily accept voluntary patients, despite their obligation to do so. Such covert policies, therefore, encourage the liberal use of compulsory orders, not always in appropriate circumstances.

Inevitably I have drawn attention to the features which highlight the divisions appearing in American psychiatry. Such a polarization produces situations where each side seeks affirmation of its own views, in turn suffering a loss of self-esteem when its tenets are dangerously at risk, or actually abandoned. In public debate, therefore, the two approaches are wide apart. In practice, clinicians continue to borrow from a wide range of theory. Many of the residents at Johns Hopkins, despite their particular bias, remain interested in other schools of thought. What they do not seem to fully appreciate is how far they have travelled down the biological road.

Part-time Training in Psychiatry: A Personal View

RHINEDD TOMS, Senior Registrar, Severalls Hospital, Colchester

In 1975, seven years after registration, I had two small children and a part-time post as Staff Medical Officer with an Area Health Authority in London. For various personal and medical reasons I had decided to have a family early in my marriage. I felt it right that their upbringing should be largely done by me, and the alternative, if I worked full time, would be to hand over their care to someone else. I knew, however, that I should not be satisfied with a purely domestic role and part-time work in occupational health provided a compromise at the time. But I was uneasily aware of the lack of a definite goal and of my own doubts about continuing long term in this type of work.

My complacency was shattered by a move to Essex as a result of my husband's change of job. Occupational health services there offered few openings and the recent Court Report made the future of community health medical officers look uncertain. I was aware of the schemes which existed to help women in my position to retrain part-time in hospital medicine or general practice, and in my occupational health post I had been interested in the amount of time taken off work because of psychiatric illness. We settled in a part of Essex which had several large psychiatric hospitals, and my choice of specialty was made.

The first step was surprisingly easy. I called on the clinical tutor in the local general hospital who immediately put me in touch with his counterpart in psychiatry. Later the same day I was explaining my aim to the chairman of the Psychiatric Division who was intrigued and sympathetic. I wrote to him officially, requesting a supernumerary training post in general adult psychiatry under the retraining scheme for doctors with domestic commitments, disability or ill health, and the application began its progress through the system, being dealt with largely at Area Health Authority level.

I was prepared for a delay of some months but in the meantime worked in various locum posts, thus gaining almost a year's experience in psychiatry before the supernumerary post was approved. In April 1977 I started work as a registrar for five sessions a week. Implicit in the arrangements was the expectation that I should work towards the MRCPsych. I moved through the various units in the hospital, as did the full-time trainees.

From the start I found myself working as a member of a unit with responsibility for both short- and long-stay inpatients, as well as out-patients. I arranged my work so that I was in the hospital for part of each day. In psychiatry part-time workers are probably more common than in many other hospital specialties, so my position was not particularly unusual, and work was organized so that both full- and part-time doctors carried similar responsibilities. There were obvious disadvantages in that one was not always available to deal with patients' problems personally, but full-time trainees, too, were sometimes away from the hospital, at out-patient clinics, on courses and so on. Problems, apart from really pressing ones, tended to be kept until I could next