The heartland of psychiatry, revisited

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Abstract

In 2007 John Geddes and I published an editorial in the British Journal of Psychiatry in which we highlighted the adoption of schizophrenia as psychiatry's heartland and its largely negative consequences for the practice of psychiatry as a distinctive medical specialty (1). It did not have a very wide impact. I received a few friendly emails (or maybe people even wrote letters then) but it has rarely been cited.

I suppose there was a kind of Schadenfreude, therefore, when it was made public that in 2011, in England and Wales, just 83% of the 478 first year (CT1) vacancies to train in psychiatry were filled. Earlier data showed that of those filling such posts, only 14% had been trained in the UK (2). This represented the lowest ratio of home qualified doctors training for any medical specialty. These findings suggest that psychiatry has become the least attractive specialty in medicine for UK graduates. And these are, of course, the graduates who will have encountered UK psychiatry as medical students.

It is certainly the case, and it was really what spurred me to make the connection in the first place, that recruitment of academically inclined doctors had declined to a trickle in a centre like Oxford that I know well. The Royal College of Psychiatrists, having slowly woken up to the problem, has now implemented a strategy to try and reverse the situation.

However, the other argument was that bipolar disorder is the heartland of psychiatry, whatever the parochial problems we face for psychiatric recruitment in this country. Of course, we had no desire to diminish the absolute importance of schizophrenia (I was asked quite seriously by one colleague if I disliked schizophrenic patients), just to restore the balance with bipolar disorder and to see how its challenges broaden the scope and interest of psychiatry as a medical specialty. It remains the case that, in almost every respect, bipolar disorder would have afforded psychiatry a model within which the medical role is easier to define than for schizophrenia, and the development of which could have informed psychiatric services in general. There could have been and still could be a better balance between medical, psychological and social care. We made this argument from a number of perspectives. First, the course of illness in bipolar disorder allows a much more meaningful distinction between the needs of patients for sympathetic inpatient respite care when acutely ill and for outpatient-based interventions when well. Second, its treatment is less amenable to one-size-fits-all social care, and bipolar disorder is more likely to challenge clinicians to understand the illness and its treatment in a therapeutic relation with individual and autonomous patients. Third, the use of rational pharmacology linked with the facilitation of behaviour change is the key modern activity of physicians treating all common illnesses.

The final point we made in 2007, was that treatment of bipolar disorder demonstrably requires medical expertise in which we should take pride. This argument for expertise can now be formalized

on the basis of a pragmatic trial over 6 years in Denmark where specialized care for bipolar patients was shown to be superior to standard care (3). The need to develop expert services for bipolar patients is underlined by the developments in pharmacotherapy and the emphasis in treatments on education and behaviour rather than more conventional 'therapy'. There is a distinction between acute and long-term medication and there is active involvement by patients in managing acute exacerbations of symptoms. Psychological treatments complement the medical approach, and enhanced care is an objective for all patients. Therefore, prescribing for and managing bipolar patients requires the key elements of expertise: knowledge, skill and experience (4).

The broader implications of our failing model for psychiatric care, or at least for the place of psychiatrists within it, remain, however. The same mentality that neglects specialist diagnosis and treatment replaces it with something vacuous and imprecise. We previously expressed the view that our heartland must be fruitful, not a barren wilderness of good intentions. Consider the following amazing piece of prose (5):

New Ways of Working is what it says – new ways of working – rather than a single service model or structure that has to be adopted. It recognises that services catering for the different types of needs of service users across their lifespan and differing demographics and geography will need different configurations to manage their task most effectively. However, the underlying principles relating to using the skills of the workforce in the most productive way are common. It is about achieving cultural change; a shift in the way teams think about themselves, the skills of the individuals within them, and the reasons they are there. However, cultural change is difficult to achieve and it is difficult to measure the extent to which it has been achieved.

It has all the charm of a pamphlet extolling the virtues of a Soviet collective farm. When I get an outstanding medical student express an interest in psychiatry, would I be wise to have them read these inspiring words, ending as they do with a sentence that embodies exhaustion and futility?

The role of doctors will undoubtedly evolve as knowledge, and perverse ignorance become more universally available to all via the internet. The role of the psychiatrist must be to relate real advances in understanding and practice to the care that is actually delivered. At present it seems rather to be to sit in endless meetings and take responsibility for other people's decisions. It becomes more not less important that psychiatrists have an academic understanding of what they are doing and a clear role within the services in which they work. Re-discovering the need for expert treatment in bipolar disorder could be a good place to start.

GP Comment

What have I learned from this paper?

I found this article very thought provoking.

The management of bipolar disorder is similar to all long-term conditions as it requires effective teamwork and excellent communication between specialist secondary care, primary care, psychological and social care.

There is an undoubted need for specialist advice in diagnosis, drug treatment plus speedy access to care for acute episodes.

Facilitation of behavioural change, as for all long-term conditions treated in primary care, is a challenge. Also patients on lithium need regular blood tests.

A trusting relationship with the patient, teamwork and, most important, concordance of advice from all professionals and carers help to improve patient compliance and health outcome. Successful teamwork benefits professionals too, by increasing work satisfaction.

The challenge in the hurly-burly of the modern NHS is to devote time to team building. I hope all newly-appointed GP commissioners will seize the gauntlet and support the creation of effective teams.

It is very unfortunate that currently psychiatry is the least attractive speciality to pursue but let us hope prospective candidates will read this article, as they are vital members of the team!

Dr Anthea Robinson, GP, Bedfordshire.

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Declarations of interest.

GG is a psychiatrist and holds a Honorary Consultant contract with the Oxford Health NHS Foundation Trust. He has received honoraria from AstraZeneca, BMS, Lundbeck, Sanofi-Aventis, Servier, holds shares in P1vital ltd; has served on advisory boards for AstraZeneca, BMS, Boehringer Ingelheim, Cephalon, Janssen-Cilag, Eli Lilly, Lundbeck, Otsuka, P1Vital, Roche, Servier, Shering Plough, Shire, Takeda, Wyeth and acted as an expert witness for Eli Lilly.

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