Alienation of the alienist: psychiatry on the ropes?

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This article is the final in a three-part series entitled 'Sense and Sensibility: Society, Medicine and its Practitioners'.

Introduction

In the UK, doctors of all disciplines are currently facing an onslaught of austerity-related and bureaucratically driven attacks. These include centrally imposed changes to the terms and conditions of their work, changes to their pay and pensions and the largest reorganisation of the clinical services since the foundation of the National Health Service (NHS) in 1948. Faced with this onslaught, it is hardly surprising that many doctors feel dispirited and that morale within the health service workforce is extremely fragile. Indeed, in the most recent annual survey of NHS staff, over one-third reported feeling unwell as a result of work-related stress.¹ Of all the medical specialties, arguably psychiatry is facing some of the biggest threats. Psychiatrists have been regularly under fire since the first asylums opened. But failure to reach agreement about basic matters such as the nature of our classification system² fuels doubts about the usefulness of our work – and we must guard against the risk of appearing weak and disorganised in the face of the ever-present threat of cuts. There is no doubt that the Diagnostic and Statistical Manual reflects current psychiatric practice in the USA and is a representation of the cultural values which may be dictated by stakeholders.

In this essay, we describe the current threats to psychiatry and suggest some strategies for the survival of our profession. Historically, psychiatrists were known as 'alienists' until about 100 years ago. Their current alienation from their paymasters and policy makers (representing the society) is a major challenge in ensuring that recruitment and training continue apace.

Threats to psychiatry

The threats, whether real or perceived, can be divided into internal and external. Internal threats relate to those from within the profession and external ones to

those which reflect pressures from other settings and stakeholders.

External threats

Changes related to healthcare and medical education policies are significant threats.³ In addition, pressure from outside from antipsychiatry groups poses a degree of threat. Increasing specialisation may lead to further fragmentation of views and contribute to the profession's inability to speak with a single voice. There are also external threats from other health professional groups. For example, while giving nurse practitioners prescribing privileges may improve access to treatment for some conditions, this effectively gives away a key task associated with the role of a psychiatrist. Changing patient expectations can equally cause the profession to feel under siege. For example, pressures towards increased consumerism, where health itself becomes a commodity to be bought or sold, have an impact on the therapeutic alliance between doctor and patient. In the present economic climate, pressures to focus on bottom line financial resources add another dimension for the professionals to deal with.

Internal factors contributing to the threat to our profession include feelings of loss of autonomy and self-regulation. In addition, competing views which highlight biological factors or social factors as causative and management strategies suggest to the outsider that the profession does not appear to agree on what it stands for. Furthermore, from within the profession tension between generalists and specialists creates further conflict. Criticism of various models within the profession makes the profession look divided and at war with itself. This inability to stand up with a clear vision and to challenge the threats is a potentially dangerous situation where an internalised view may lead to a sense of hopelessness. The combination of low morale and entrapment is further disheartening and can cause the profession to go into a vicious downward spiral.

Response by the profession

Professionalism has generated a lot of interest in the past decade or so. The American College of Physicians³ and The Royal College of Physicians⁴ have defined professionalism. In a survey of psychiatrists,⁵ the respondents were generally aware of the concept of professionalism and its components, including skills, training, ethics, autonomy, responsibility, accountability, competency, expertise, integrity, maintaining standards and self-regulation, with clear evidence base of knowledge to be followed. It was suggested by the respondents that the profession must take the lead on defining, developing and delivering professionalism as it related to psychiatry. In a survey of clinical tutors responsible for training in the UK and Eire, the top four characteristics of a good psychiatrist⁶ were identified as overall competency in diagnosis, investigation and management; being a good communicator; the ability to make appropriate clinical decisions; and being a team worker (where individual opinions are valued and team members have a sense of ownership of clinical decisions). It is important that the professionals themselves set standards of care which are delivered within the limits set by available resources. They also have a responsibility to ensure that the society and the policy makers are aware of what can be achieved within the given resources and what cannot be, so that everyone is crystal clear.

The core of professionalism³ is about primacy of patient welfare (which dates back to Hippocrates embedded in the principle that first do no harm); patient autonomy and social justice. All the professional responsibilities are related to this core. In addition, commitment to professional competence, honesty with patients, patient confidentiality, appropriate relationships with patients (and other team members), improving quality and access to care, just distribution of finite resources, scientific knowledge, maintaining trust by managing conflicts of interest, professional responsibilities of being respectful of one another, maintaining patient care, self-regulation including remediation and disciplining are all important aspects of professionalism whatever the medical specialty is. Professionalism places the interests of the patient above those of the physician. The practice of psychiatry, along with other medical disciplines, faces unprecedented challenges. The role of the doctor in managing disparate demands and competing tensions for limited resources make it likely that at times patients' needs may not be met. An increasing emphasis on free-market business model-based processes puts an inordinate amount of pressure on psychiatry and psychiatrists. These challenges have to be tackled head on. As Shock⁷

emphasised, medical professionalism was shaped over a century ago by class structures, a society dominated by production and the doctrine of liberalism. Health became a commodity and also became political about three decades ago.⁸ Research, training, monitoring of new interventions, and continual monitoring of quality and improvement are the best ways the profession can respond.

Gilbert and Allan⁹ suggested that feelings and perception of defeat (as reflected in hopelessness) and a sense of entrapment may lead to depression. We hypothesise that, as a profession, psychiatry may have entered a 'depressive phase'. From the low levels of morale and high levels of burnout as recently reported in a local survey (Royal College of Psychiatrists unpublished data), it certainly appears likely that the profession itself is under severe existential threat. Depression, of course, is associated with an increased likelihood of suicide and self-harm, and we must guard against the possibility of unwittingly committing professional suicide by fighting among ourselves. Loss of energy, loss of interest and impairment of psychological abilities all reflect presence of depression (see Gilbert and Allan⁹). We suggest that a more healthy and productive way out of this depression is to change our cognitions about our profession, who we are and what we can achieve when we confront these challenges. A major first step is to recognise our strengths and positive aspects and to take pride in what we do.

What does the future hold for psychiatry?

Psychiatry has a glittering future provided its practitioners are able to speak cogently and clearly.

Leadership

Clear leadership is required by psychiatrists in these times of unparalleled turmoil, more evident in the UK and Western Europe and to a degree in the USA, although the challenges are truly global. Clinicians know and understand the needs of their patients and the time is ripe for patients and psychiatrists to work together to advocate for each other. Leadership is never given but has to be earned, and clinicians must take the lead not only in planning and delivering services but also in evaluating them in order to ensure that services are both effective and efficacious. Training in medicine and psychiatry makes it easier for psychiatrists to acquire skills which will enable them to become successful leaders. In the modern turmoil in the NHS, at least on paper, clinicians have responsibility for

commissioning and the management of resources. In reality, however, there is insufficient time for doctors to take on these roles in addition to their primary role of clinician.

Biopsychosocial training

For decades there has been an ongoing debate within the profession about the primacy of biological causation over social, and *vice versa*. The truth as ever is in the middle. Medicine itself cannot be understood or practised without understanding both the biological and social context. To this end, only psychiatrists in the team are trained to evaluate, understand and use biopsychosocial models. Other members have expertise in unitary models. This training and unique skill-mix places the psychiatrist in the very best position to lead clinical teams.

Furthermore, psychiatrists can facilitate a number of interfaces and interactions. As Glasziou *et al.*¹⁰ have recently argued, doctors are so busy managing risk factors that they often lack the time to care properly for those who are seriously ill. This is where psychiatry comes into its own. We have been managing risk as well as ambiguity for a long time and also caring for the seriously ill, so we have skills which can be shared with others.

Psychiatric subspecialties and their survival

As professions evolve, it is inevitable that further specialization will occur, which should benefit patients. However, a major downside of this increased specialisation is that the chances of the profession fragmenting increase, making it harder for any one individual to advocate for the entire profession. The debate between specialism and generalism needs to be resolved urgently. Specialisms are important, but in the absence of a robust generalist foundation these will be vulnerable to allegations of special interests.

The external challenges to psychiatry as highlighted above are many, and the only way these can be overcome is by single-minded purpose to ensure that the profession's voice is heard clearly at senior levels of policy making and this is not drowned out by self-interest. Recent experiences in the UK, where many core services – such as addictions and rehabilitation – are currently being provided by the primary care and voluntary sector, need proper evaluation. It is critical that the profession assesses these developments dispassionately and then learns relevant lessons so that delivery of services is effective and

acceptable to patients. Although the number of available acute psychiatric beds has gone down, the number of forensic (medium and high secure) beds has continued to rise. Here too the impact of such changes must be evaluated properly.

Adult psychiatry needs to revisit its core functions and values. In these straitened times, it is possible that the adult psychiatric services are currently better placed within primary care. Both primary and secondary care services need to consider the possibility of working in a truly integrated fashion with porous borders. We think that the profession should have a bigger role in the public mental health agenda, including the promotion of mental health.^{11,12} By and large psychiatrists have been reticent in becoming involved in the prevention of mental ill health and the promotion of mental health. However, both these activities are crucial to the wellbeing of our society as a whole and the profession should consider the opportunities afforded by taking on these responsibilities.

Medical psychotherapy in the present era is particularly at risk in the UK. This can be attributed to a number of factors. Of these, the most recent is the increased Access to Psychological Therapies. These changes, although welcome in the overall scheme of things, do not bode well for medical psychotherapists unless they change their ways of working. Medical psychotherapists elsewhere must look out for these challenges and respond accordingly.

Psychiatry as a profession is on the verge of new therapies through psychopharmacogenomics, neurosciences of emotions and web-based therapies. President Obama has recently declared a decade of brain research, a project investing heavily in examining the workings of the human brain. There are exciting opportunities.

Gilbert¹³ has suggested elsewhere that depression is loss of control over aversive events and/or major resources/rewards and can produce downwards effect on positive affect. Combined with loss of control, depression may become more serious, hence an urgent need to deal with socially unsupportive and hostile environments. We urge the profession to take a united stand to overcome this lethargy and attacks from various directions. Psychiatry remains the most complex and most challenging medical speciality and we must ensure that our patients get the best services they deserve.

These are exciting times and the profession needs to take pride in its achievements in caring for some of the most complex and deprived patients. This pride needs to be conveyed in order to attract bright enthusiastic trainees so that future generations of patients can be served well.

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