

- (f) On the other hand, as a GP, I would certainly consider carefully who to refer to secondary care and would use all my skills, as acquired in my GP training, before referral. I would also consult my liaison community psychiatric nurse or other attached mental health professional if I had one, and if necessary consult the consultant psychiatrist over the phone. However, a good GP will expect to be able to refer problems which they cannot solve to secondary care, and then expect the referral to be treated with respect by the consultant psychiatrist colleague with an adequate response, for GPs are specialists in their own right.
- (g) Finally, in all of this debate, we have entirely forgotten that the reason service users consult doctors is the doctor–patient relationship, which is a relationship based on trust in another person, who may or may not have a greater or lesser knowledge of psychology and neuroscience, but who most of all is a person to be confided in during difficult times. This is what we must be as doctors, and all our discussions about ‘the role of the consultant’ pales into insignificance before this.

We must remember how Sir James Spence defined the consultation: ‘The occasion when, in the intimacy of the consulting room, a person who is ill, or believes himself to be ill, seeks the advice of a doctor whom he trusts. This is a consultation.’<sup>2</sup> If we forget this, then what indeed is the point of our being doctors?

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- 2 Spence J. The need for understanding the individual as a part of the training and functions of doctors and nurses (speech delivered at a conference on mental health held in March 1949). In *The Purpose and Practice of Medicine: Selections from the Writings of Sir James Spence*: pp. 273–4. Oxford University Press, 1960.

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We welcome the debate initiated by Craddock *et al*<sup>1</sup> and agree that the role of the psychiatrist is key to the delivery of high-quality services, and may be currently threatened. However, we believe that their proposals would be restrictive and counterproductive. If the psychiatrist has to assess all those referred to secondary services, access to such care would be restricted increasing the burden of unmet need. To deploy services effectively the psychiatrist should assess only those who require their direct input, freeing-up the psychiatrist to have an overview of the clinical work of all the team members: from allocation, initial assessment and management through to discharge as well as a training and development role. This was the ambition of New Ways of Working,<sup>2</sup> although not realised in its implementation, partly due to the lack of training of the other team members for their extended role and the development of teams without adequate medical input for them to work effectively. These issues should be addressed directly. To return to a position of the consultant taking full clinical responsibility for all the team’s case-load is not only retrogressive, but unworkable. Allowing staff to take the personal responsibility that they already have improves the

quality of care delivered and works best when the consultant is readily available for consultation and review rather than running over-booked out-patient clinics as occurred hitherto.

The authors, in focusing on the importance of biomedical methods, appear to underestimate the important contribution of other approaches, psychological and social, to psychiatry, which have been shown to lead to effective interventions. The profession of medicine is changing, with our physician colleagues taking up many of the challenges of a psychosocial approach. We appreciate that psychiatry is a medical specialty and that psychiatrists are physicians who have an expertise in psycho- and socio-dynamics in their broadest forms. In reconsidering our roles and values on the 200th anniversary of our specialty we should consider what we should be doing in the 21st century and how we can adapt to this. The mental health services have far to go to improve standards, quality and the delivery of evidence-based practice. The users of these services should expect to encounter experts in the field of mental disorders, but these experts need a wide range of skills and knowledge to guide assessment (including diagnosis) and management (including treatment). But, in addition, they need to utilise the ideas of recovery<sup>3,4</sup> (a term regrettably omitted from Craddock *et al*’s paper) to negotiate and facilitate the types of goals and outcomes valued by service users and to allow people with mental disorders to participate more fully in their communities and society.

It is important not to polarise this crucial debate, nor to retreat into restrictive medical modes of thinking. To meet the challenges of the 21st century will mean an important shift in our ways of working, which can be of enormous value to our professional roles and to the service users that we work with.

- 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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The interpretation in *The Times*<sup>1</sup> of Craddock *et al*<sup>2</sup> risks alienating multidisciplinary colleagues and patients alike, turning a call for quality services into an appeal for primacy for the psychiatric profession.

New Ways of Working is similarly open to misinterpretation, including by Craddock *et al*. A fundamental principle of New Ways of Working is freeing up the appropriate staff to work with the patient. That means consultant practitioners working with those with the most complex needs – exactly what these doctors ordered.

Yet Craddock *et al* appear defensive, undermining their own call for self-confident progress. Why get exercised about

use of the term 'mental health' rather than 'mental illness'? The government has stressed repeatedly in the National Health Service Next Stage Review that maintenance of health and well-being is its job just as much as treatment of illness. Performance management, outcome measures and payment by results drive vague 'support' out of the system, promoting more structured, evidence-based care delivery.

The Future Vision Coalition, comprising leading mental health charities, directors of social services, the Mental Health Foundation and, crucially, the network of our employer trusts, has just published *A New Vision for Mental Health*,<sup>3</sup> bringing health and social models together, focusing more on health promotion and on quality of life rather than illness, and redefining relationships between services and users. If the psychiatric profession endorses Craddock *et al*'s vision instead, who is likely to end up out of step and disregarded?

The current investment in improving access to psychological therapies demonstrates how those evidence-based services have not been over-provided or over-used to date, whereas 93% of patients have been prescribed medication. The National Institute for Health and Clinical Excellence<sup>4</sup> stresses the efficacy of both psychological and psychosocial interventions. The relevant expert should lead discussions where biomedical approaches are key, but where that is not the case or the whole story, which is often, the other experts are similarly important. 'Jolly along' was seen when other professions were the handmaidens of psychiatrists, only trusted to give 'support'; now they may be prescribing as well as delivering other therapeutic interventions.

Politically correct terms like 'service user' have arisen because of stigma, which psychiatrists have played their part in perpetuating, being accused of low expectations, making assumptions about behaviour based on diagnostic labels, patronising or unhelpful letters, using patients as 'cases' for training, and promoting the 'medical' model while dismissing side-effects as 'psychological'.

Our answer to their 'thought experiment' question – would you opt for a distributed responsibility model if a member of your family was the patient – is a resounding 'yes please'. Going back to a psychiatrist with a case-load of hundreds, or awaiting the arrival of yet another locum for a decision, is neither safe nor satisfactory. Lord Darzi<sup>5</sup> heralds a 'new professionalism' based on teamwork; teams can only be efficient and effective if members are appropriately skilled, competent and take responsibility for what they do.

We agree with Craddock *et al* that psychiatry can have a great future, but only by embracing teamwork, abandoning hegemony and accepting the importance of social and psychological as well as biological determinants of mental ill health, rather than harking back to a past which was actually far from ideal.

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Craddock *et al*<sup>1</sup> present a compelling argument for retaining the biomedical model of psychiatric illness, while acknowledging that evidence-based psychosocial interventions do have an important place in management and treatment.

It is their discussion about New Ways of Working that particularly struck a chord with me. As a third-year specialist registrar who will soon be looking for consultant jobs, I find myself in a dilemma: am I for New Ways of Working or against it?

Case-loads of 300 patients seen briefly in 15-min 'routine' out-patient clinics; one urgent appointment after another; the community team, day unit and GPs all wanting their patients to be seen only by the consultant;<sup>2</sup> shouldering responsibility for patients not seen or advised on by me; to me, all of this sounds like a certain recipe for early burnout. Is it any surprise that I do not want any of this?

On the other hand, my medical training has taught me to diagnose and treat appropriately and I do this well. When other members of the team ask me to see someone who they think may have depression, my training enables me to not only exclude depression but to pick up the drowsiness, slurred speech and small pupils of morphine addiction, and to then manage the patient appropriately. As Craddock *et al* point out, having a broad-based assessment by a doctor at the first point of contact is likely to ensure that the patient gets the most appropriate treatment.

Craddock *et al* think we should be arguing for better resources and increased workforce. This is very reasonable but is it realistic?

Is the choice, then, between one's personal well-being and that of one's patients? I have not found the answer to this dilemma yet. It is reassuring to see that experienced psychiatrists have strong views on both sides, illustrated by the heated debate over the past few months. Perhaps I should sit on the fence just a little while longer.<sup>3</sup>

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We strongly support the views expressed by Craddock *et al*.<sup>1</sup> In our opinion, their perspective is shared by many NHS consultant colleagues and is not limited to academic psychiatry.

At the heart of the debate is the progressive downgrading of the role of the consultant psychiatrist in diagnosing and managing