The feasibility of a psychiatric common market

British and Continental approaches to postgraduate psychiatric training

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In 1957, the Treaty of Rome allowed free settlement of professionals, including mental health workers, across Europe. European Community (EC) Medical Directives formally regulated the recognition of medical specialists in the EC. The resulting pressures to harmonise postgraduate medical training have given rise to European criticism of the British and Irish system, mainly because of its longer duration of training (Beecham, 1992). The Calman Report (DOH, 1993) proposed radical changes to bring UK postgraduate training in line with Europe.

Four years after the Treaty of Rome was signed, Aubrey Lewis wrote "Psychiatry has certainly not yet reached a stage at which a uniform pattern of postgraduate education is to be desired. Nor is it feasible." (Lewis, 1961). The question arises whether harmonisation of psychiatric training across Europe has become feasible since.

We argue that, as regards psychiatry, the real European disparities concern style and content of training rather than the relatively straightforward issues of certification and duration; French and Dutch examples will be used to illustrate this.

Economical and manpower problems

The longer duration of psychiatric training in Britain, compared to the Continent, is mainly related to the British split between general and higher professional training. The Calman report proposes one single specialist training grade. It recognises that, with shortening of training, the service contribution by junior doctors will decrease, and competitive entry to specialist training as in France (competitive exam) and the Netherlands (highly competitive interview) encouraged.

What will the economic consequences of the proposed changes be? First, training grades may become more difficult to obtain and a proportion of junior doctors may have to work in non-training, service posts. Such a situation exists in the Netherlands and France where it has given rise to fierce competition for training posts, an acute shortage of psychiatrists, and a vast circuit of uncertified but experienced practitioners (Leyten, 1993). Second, salaries of trainees may decrease. Third, with the proposed expansion of the consultant grade, the salary and the standing of the consultants may decrease. They may become more comparable to their European colleagues and spend more time in actual contact with patients. This may increase the attraction of private practice as is already the case on the Continent. Harmonisation of training cannot be complete if health care systems remain different. For instance, although completion of specialist training on the Continent confers the right to claim specialist fees from private insurers, access to senior hospital posts has to be gained by gradually climbing the career ladder. Under Euro-rules, newly qualified continental psychiatrists would be automatically eligible for appointment as consultants in the British NHS.

Thorny issues – psychotherapy and neurology

In France, psychiatry has long remained subordinate to neurology. Links between the universities and the asylums did not develop until the 1960s. The current French training schemes were born out of a crisis during the 1968 revolts when discontented asylum psychiatrists demanded complete separation of their discipline from the domination of neurology (or even medicine), and closer links between the state hospitals and academic psychiatry. The historical context of French and British training schemes differ markedly in their relation with neurology and also in the history of their academic development (early in Britain, late in France). Psychotherapy training is not part of the British

https://doi.org/10.1192/pb.18.4.193 Published online by Cambridge University Press

and French curricula. However, the historical reasons for this differ. In Britain, psychoanalysis became firmly established only in London, thus virtually excluding from training those who work in peripheral centres. French psychiatry, facing competition from neurology, may have felt the need to maintain a medical emphasis, at the expense of psychotherapy.

This contrasts with the Dutch situation. The present training represents a compromise between the neurologists and the analysts, ensuring that medically skilled psychiatrists can compete successfully with non-medically qualified psychotherapists. The Dutch guidelines stipulate that the trainee should treat a specified minimum number of somatically-neurologically ill patients and also prescribes a personal therapy (paid for by the hospital).

Lewis (1946) described neurology and psychotherapy as 'thorny' problems for psychiatric trainers and it would appear this still seems the case. Dutch psychiatrists are automatically also registered as psychotherapists. Will, under the Medical Directives, a British or French psychiatrist without any training in psychotherapy be entitled to the qualification of psychotherapist in the Netherlands?

Specialisation and research

Britain is the only country with separate higher training programmes in five adult psychiatric subspecialties. It has been possible to develop such specialised training because of the split between general and higher psychiatric training which would now be abolished as proposed under the Calman report. This could have profound implications for the subspecialties.

The Medical Directives do not recognise these subspecialties and any European psychiatrist should be eligible to be appointed in Britain in any adult specialty. This disparity between the UK and the Continent regarding subspecialisation may rekindle the argument about the status of full-time psychiatric specialists.

The senior registrar component of British training has allowed emphasis on training in supervised research which shortening of training prior to consultant appointment will diminish. Hence, the research status of British psychiatry may suffer as a result of Euro-harmonisation.

Historical differences

Sociocultural factors affect psychiatry more than most other medical disciplines. Psychiatric style is not similar across Europe and subtle cultural and historical differences between national schools of psychiatry may eventually prove more difficult to overcome than organisational and economic problems.

Dutch psychiatry has historically had a keen interest in religious and philosophical matters. Religious organisations have traditionally provided a substantial proportion of the psychiatric bed capacity, and many more Dutch than British or French psychiatrists have written about religious problems in relation to psychiatric disorder. After the second World War, a religiously coloured variant of existentialism became popular in the Netherlands. This had a decisive influence on the development of Dutch forensic psychiatry and may also have fostered the prominence of psychotherapy and the occasional dismissive attitude of Dutch psychiatry towards empirical research. The Dutch preparedness to compromise between scientific and more subjective approaches to psychiatry was already summarised by Rümke: "Psychiatry does neither belong exclusively to the natural sciences, nor to the humanities" (Rümke, 1937).

French psychiatric training was born out of an ideological crisis and remains undecided about the place of psychological treatments. Although no formal attention is paid to psychotherapy in training, it has a prominent place in practice. French psychiatry never followed Kraepelin and continues to use its own system of classifying mental illness. Henri Ey, who developed the present curriculum, exemplifies the somewhat precarious position of French psychiatry between psychotherapy and neurology. He defines psychiatry as a branch of somatic medicine and blames psychodynamic and social theories for not being medical enough. However, he also scolds organic psychiatrists for not distinguishing themselves enough from neurologists (Ey *et al*, 1978).

British psychiatry did not have to struggle with the opposing demands of neurology and psychotherapy, and has been able to devote its energies to the development of psychiatry as a scientific discipline. This difference in emphasis between British and Continental training is likely to cause obstacles for psychiatrists who wish to emigrate in both directions; we heard of a British trained psychiatrist who went for a job interview in the Netherlands (SR equivalent) and was told that he had overemphasised research and paid too little attention to clinical interests – feedback unlikely to be received in Britain.

Conclusion

Significant differences remain between psychiatric training programmes in European countries. These differences are partly related to differences in the organisation of the health care systems and to different developments of

https://doi.org/10.1192/pb.18.4.193 Published online by Cambridge University Press

psychological medicine, particularly as regards attitudes toward neurology and psychotherapy. The attitudes and personalities of national psychiatric leaders have left their mark on training in the respective countries.

Although the main political worry at present seems to be the duration of training, as far as psychiatry is concerned, this is probably a spurious problem. British psychiatry may gain from harmonisation in some respects, especially if it leads to a clear position on the issue of psychotherapy. But losses may occur on other fronts such as manpower and excellence in subspecialties and research.

Acknowledgement

Parts of the material in this paper were presented by the first author at the Royal Society of Medicine, Psychiatric Section Meeting, 11 May 1993. Acknowledgements to Professor Anthony Mann.

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https://doi.org/10.1192/pb.18.4.193 Published online by Cambridge University Press