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Keynotes

The general psychiatrist as specialist*

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Although the definition of a specialist as an individual knowing "more and more" about "less and less" could be construed as a somewhat cynical critique of certain aspects of contemporary psychiatry, the *Universal English Dictionary* defines a specialist as a person engaged in a "special line of study or special branch of a profession"; a definition more relevant to this article which attempts to resolve the paradox of the "generalist as specialist", and to outline the way in which general psychiatry *is* a special branch of a profession.

Undoubtedly at the present time there is a tendency within medicine towards greater specialisation; a trend accelerated by advances in biomedical technology and closely linked to 'new' specialties such as clinical neurological physiology, paediatric surgery and neonatology. Parry-Jones (1991) has likewise predicted that the existing list of sub-specialties within psychiatry is also likely to extend and include psychiatric traumatology, family therapy, neurobehavioural psychiatry, and psychiatric molecular genetics – and even the latest conception 'infant psychiatry'. There is a wish by these new specialty professionals to possess an expertise not shared with others, not only because patients may demand it or insurance policies insist on it, but also because of the intellectual satisfaction that such mastery provides.

In the USA, however, such inter-specialist divisions, though less developed in psychiatry, have already led to the disadvantage of "touting for patients" and a fear of litigation, as well as to defensive medicine if a heart specialist treats a gut problem or an affective disorder expert diagnoses schizophrenia (Yager, 1989), or in the UK if a child and adolescent psychiatrist treats an elderly alcoholic.

Yet the practice of a broadly based general psychiatry can be as intellectually rigorous and demanding as for other specialties and is necessary for optimum patient care. In Yager's book *The Future of Psychiatry as a Medical Speciality* the possible problems for the consumer in the USA who is denied access to a sectorised general practitioner are illustrated; a cogent caveat about the risks of excessive sub-specialisation within psychiatry. In the USA a patient has to choose which specialist to refer himself to when woken with a severe pain in his left groin, is certain he has a kidney stone, and must establish where there is a good doctor to take out his stone. The question is posed "even if your doctor *has* a diploma on his wall saying that he graduated from a medical school with 90% average, maybe he only got 60% for the kidney"! Nonetheless, Yager concluded that the consumers of psychiatric services, both physicians and the public, *are* increasingly specific about knowing what they need, and will seek out the best available advice. Thus a cardiologist may wish to refer a patient only to a psychiatrist with special knowledge of the effect of tricyclic antidepressants on the bundle of His, or a phobic patient insist on consulting a psychiatrist with a recognised expertise in the management of phobias.

Although the momentum in the UK towards further specialisation is considerable and probably inexorable, some general physicians have recognised the clinical and professional disadvantages of moving too far from the "common trunk" of general medicine (Editorial, 1990); the belated establishment of a General Psychiatry Section is likewise an acknowledgement that super-specialisation may be disadvantageous. Indeed a neglect of the "core speciality" of general psychiatry as enshrined within the Membership examination could lead to an administrative hiatus caused by "the tail wagging the dog" or, more importantly, to very dissatisfied general practitioners whose highest priority is to have acute emergencies rapidly assessed and, if necessary, admitted to hospital (Holmes, 1992).

According to the Department of Health there are six sub-specialties of psychiatry: old age, child and adolescent, forensic, psychotherapy, mental handicap, and adult mental illness; there are no defined specialties of social or community psychiatry, liaison, neuropsychiatry, rehabilitation or substance abuse. These broad bureaucratic groupings, of which by far the largest is adult mental illness, are nevertheless important as they determine the number of senior registrars and consultants within

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a speciality. The recent establishment of old age psychiatry as a Department of Health specialty has, for example, had the immediate effect of diverting adult psychiatry senior registrar posts into this specialty at a time when there are vacant general psychiatry consultant posts. The criteria for establishing these particular specialties are heterogenous and include age (old age, child and adolescent); specific treatment approach (psychotherapy) or a specific expertise such as knowledge of the law and the needs of the mentally abnormal offender (forensic).

What therefore *are* the specific characteristics of the general psychiatrist as a specialist? The answer to this question is linked to the basic assumption that general psychiatry, like the Membership Examination, has roots firmly within three core sciences – biology, psychology and sociology (including some aspects of social anthropology), and that to treat a patient (acute or chronic) with a disturbance of intellect, emotion or behaviour, a general psychiatrist is required to be familiar with explanatory theories derived from these sciences *and to know when and how to move from one treatment approach to another*. The synthesis of these core sciences based on a general systems theory is, according to Weissman & Bashok (1989), the hallmark of the practice of general psychiatry. The biopsychosocial model of Engel (1980) is also based on systems theory and similarly points to the interdependence of these sciences. For individuals with a particular sensitivity to more abstract "spiritual" perspectives, "holistic" psychiatry is a label which may sustain a multi-model psychiatry. Joining the Ancient School of Eclectic Philosophy is regrettably still stigmatised as shallow thinking rather than an appropriate awareness that models *are* only models, and that the total understanding of human nature cannot be confined to biological or behavioural sciences alone. It is this breadth of training of a psychiatrist in the social as well as biological sciences which can contrast with that of other mental health professionals, and which underpins the distinctive tasks of the generalist. This is an overlooked reason why psychiatry should retain a persistent appeal to doctors who increasingly recognise the limitations of biomedical reductionism which characterises much medical and surgical teaching. In what other medical specialty is psychology and sociology *necessary* reading for "good practice", and career progress? This fact could be a more established recruiting platform for psychiatrists, and improve further the quantity and quality of applicants for both undergraduate and postgraduate training.

These clinical skills of a general psychiatrist are used in the assessment of unselected patients at home, health centre or hospital, and in particular in the management of acute emergencies. In addition the general psychiatrist's approach is important in sector psychiatry, the organisation and ethos of an admission ward, and for the full assessment of patients with physical and psychiatric problems. To this extent while basic general professional training for the MRCPsych examination is central to acquiring the knowledge, skills and attitudes necessary for the general psychiatrist, these abilities need to be enlarged and rehearsed during higher professional training and throughout continuing medical education.

As most general psychiatrists are community psychiatrists in the sense that their work extends outside the hospital into the community, some distinctions between Sections are artificial and can lead to 'splitting' which may diminish valuable cross-specialty interaction, such as that between adult and child psychiatrists, and general and forensic psychiatrists; some "community" psychiatrists have lost touch with their hospital based generalist colleagues, to mutual disadvantage.

The general psychiatrist and the General Psychiatry Section is a bridgehead between the intellectual and practical inadequacy of a uniform generic sector service and such a narrow specialisation which, outside a research endeavour, may lead to petty conflict and the marginalising of psychiatric expertise in a multi-professional team. Thus to retain credibility as leader of a multi-professional team, the consultant is required to be trained in the principles and practice of the psychotherapies and to be familiar with Rogerian counselling.

The "specialty" of general psychiatry depends intrinsically on the interchange of ideas *between* different viewpoints and theoretical advocates. The ability to sustain disagreement and an awareness that knowledge in psychiatry is partial are, in this writer's opinion, specifically characteristic of a general psychiatrist's approach.

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