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A big tent?

I have carried out neurobiological research in academic psychiatry for 30 years and find much to endorse in the editorial by Bracken & Thomas.[1] Being trusted with the life experiences of others is a privilege, and participating in the construction of shared narratives is a key psychiatric skill. My reservation is how far the authors relish diversity when it comes to views that are not in agreement with their own. For example, while Holloway's balanced and well-reasoned response[2] is castigated for reducing 'complex issues to simple binaries, "heroes . . . [and] . . . villains,"' the authors seem to me rather binary themselves ('sickened by the corruption of academic psychiatry') and also curiously disengaged from a central problem – that of coercion.

The notion that people with bipolar disorder have 'a dangerous gift to be cultivated and taken care of' makes a lot of narrative sense to me and, anyway, how could I possibly object if that is how a person wants to see it? However, if that person's behaviour threatens the well-being and safety of others, there may well be irreconcilable conflicts of understanding, which could lead to compulsory hospitalisation and treatment, no matter how expert a psychiatric team might be in engaging with diverse perspectives. I do not know what the answer to this problem is, or even whether psychiatrists should be involved in it, but it seems to me an overwhelmingly political issue that marks psychiatry off from other medical specialties much more clearly than the social construction of diagnosis, which after all is as much the case for heart disease as it is for psychiatric disorder.[4] On the other hand, if someone wishes to see their heart disease as a spiritual problem and reject biomedical treatment, even if it puts their life in jeopardy, they run no risk of being compulsorily admitted to hospital and forcibly administered aspirin and statins.

I think that Bracken & Thomas might also be more open-minded about what biomedical science can do for us. I say this with trepidation (and the near-certainty of betraying 'serious misunderstanding'), because the authors obviously have a healthy respect for their expertise in continental philosophy and the philosophy of science. Nevertheless, how far our culturally based scientific practices can give us access to a real external world is a complex and contested issue.[5] What does seem to be the case is that modern science not only provides explanatory models (innumerable discourses do that), but uniquely, for better or worse, gives us some degree of mastery over the natural world. The ability of vaccination to eradicate smallpox was not culturally contextual, even though the germ theory might be.

Of course, it may be that the tools of biomedical science are simply inappropriate for helping people with what we currently call psychiatric problems. This is a perfectly coherent intellectual view, and ultimately it is up to a democratic society to decide whether it wants to pay for medical doctors and medical science to be involved. Bracken & Thomas seem to believe that there is a role for medicine and science in psychiatry, but I just do not know whether their 'authentic science of human beings' accommodates, for example, cognitive neuroscience. If it does, we have an exciting project.

1 Bracken P, Thomas P. Beyond consultation: the challenge of working with user/survivor and carer groups. *Psychiatr Bull* 2009; **33**: 241–3.

2 Holloway F. Common sense, nonsense and the new culture wars within psychiatry. Invited commentary on . . . Beyond consultation. *Psychiatr Bull* 2009; **33**: 243–4.

3 Bracken P, Thomas P. Authors' response. Invited commentary on . . . Beyond consultation. *Psychiatr Bull* 2009; **33**: 245–6.

4 Searle JR. *The Construction of Social Reality*. Penguin Books, 1995.

5 Dreyfus HL. How Heidegger defends the possibility of a correspondence theory of truth with respect to the entities of natural science. In *The Practice Turn in Contemporary Theory* (eds TR Schatzki, K Knorr-Cetina, E von Savigny): 151–62. Routledge, 2000.

Declaration of interest

P.J.C. has been a paid advisor to pharmaceutical companies engaged in the development of antidepressant drugs and has provided expert advice in legal cases involving psychotropic drug treatment.

Philip J. Cowen MRC Clinical Scientist, University of Oxford, Neurosciences Building, Warneford Hospital, Oxford OX3 7JX, email: phil.cowen@psych.ox.ac.uk

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Critical psychiatry seeks to avoid the polarisation engendered by anti-psychiatry

Frank Holloway wonders whether he has missed a subtle distinction between the constructs of post-psychiatry and critical psychiatry.[1] Post-psychiatry is one form of critical psychiatry, perhaps the best articulated.[2] Critical psychiatry covers a broad range of opinion. A fundamental debate within critical psychiatry is about how much can be achieved within psychiatry. Critical psychiatry is not necessarily tied to postmodernism, as is post-psychiatry.

Holloway also suggests that post-psychiatry is 'strikingly similar to the anti-psychiatry movement of the 1970s', but does not explain in what way. Indeed, there are links between anti-psychiatry and critical psychiatry, which critical psychiatry has not been afraid to hide.[3] However, it should be remembered that both R.D. Laing and Thomas Szasz, perhaps the two psychiatrists most commonly associated with the term, disowned the use of it of themselves. Moreover, there are significant differences between the views of Laing and Szasz, which are frequently glossed over. Essentially, 'anti-psychiatry' has been used by the mainstream to disparage any opposition. I worry that Holloway is also using the term in this way when he talks about the new culture war between critical psychiatry and academic psychiatry.

Holloway expresses concern that the casualties of this war will include most mental health professionals who take an eclectic approach to their work. True, eclecticism was the compromise outcome of the anti-psychiatry debate, perhaps

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best represented by Anthony Clare's book *Psychiatry in Dissent*, which Holloway quotes.[4] Clare eschewed a well-defined basis for practice. In the recent issue of the *British Journal of Psychiatry*, Nassir Ghaemi argues for the need to move beyond such eclecticism.[5] Critical psychiatry is a potential way forward.

1 Holloway F. Common sense, nonsense and the new culture wars within psychiatry. Invited commentary on . . . Beyond consultation. *Psychiatr Bull* 2009; **33**: 243–4.

2 Double DB (ed). *Critical Psychiatry: The Limits of Madness*. Palgrave Macmillan, 2006.

3 Double DB. Historical perspectives on anti-psychiatry. In *Critical Psychiatry: The Limits of Madness*: 19–39. Palgrave Macmillan, 2006.

4 Clare A. *Psychiatry in Dissent*. Tavistock Publications, 1977.

5 Ghaemi SN. The rise and fall of the biopsychosocial model. *Br J Psychiatry* 2009; **195**: 3–4.

Declaration of interest

D.B.D. is a member of the Critical Psychiatry Network.

D. B. Double Consultant Psychiatrist, Norfolk and Waveney Mental Health NHS Foundation Trust, Northgate Hospital, Great Yarmouth, Norfolk NR30 1BU, email: d.double@uea.ac.uk

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New Ways of Working: are we prepared?

We completed an audit on New Ways of Working to compare the 60 most recent histories taken by junior doctors (STR1–3, including general practice trainees) and nursing staff in an out-patient clinic. The audit was done in Lymebrook Centre, which is one of the resource centres that caters for adult psychiatric patients in North Staffordshire Combined Healthcare NHS Trust.

All histories were assessed for 108 variables. In addition to assessing whether the relevant variable was reported, we also graded the information reported on whether it was comprehensive or only partially obtained. The data were collected on hard copy and analysed on SPSS version 13 for Windows.

This audit showed significant differences in histories taken by junior doctors and nurses. Doctors documented comprehensive histories for 52% of variables; they took incomplete histories for 8% of variables and did not ask for 39% of variables. Nurses have taken comprehensive histories for 32% of variables; they have taken incomplete histories for 13% and did not ask about histories for 55% of variables. There were statistically significant differences ($P<0.05$) between the two groups in 44 out of the 108 variables, with doctors generally taking a more comprehensive and detailed assessment. The audit was presented within the Trust; nurses' representatives were asked for their views. They stated that history-taking, physical examination and pharmacology are not part of their nursing training, therefore they are not confident in these aspects of patient care (e.g. physical, pharmacological). They have identified difficulties in differentiating physical symptoms because of functional and biological causes. Torn & McNichol[1] found that 96% of nurse practitioners did not feel that their training adequately equips them to treat people with mental health problems and 83% did not feel adequately equipped to assess people with mental health problems. No other independent studies have since been completed and there is no other evidence available which would support New Ways of Working.

It is certain that psychiatry needs to change to provide better patient care and to overcome difficulties posed to the psychiatrists, but are we ready for it?

1 Torn A, McNichol E . Can mental health nurse be a nurse practitioner? *Nurs Stand* 1996; **11**: 39–44.

Sandeep Bansal Speciality Registrar (CT3), DASH team, c/o Dr Bhunnoo, St Ann's Hospital, St Ann's Road, Tottenham, London N15 3TH, email: drsanban@googlemail.com

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The trouble with . . .

In two related articles – 'The trouble with NHS psychiatry in England'[1] and 'New Ways not Working? Psychiatrists' attitudes'[2] – misgivings about the role of the psychiatrist and service delivery in England are described. As psychiatrists working in Scotland, we have witnessed a divergence between the two National Health Services since devolution. The National Service Framework for mental health,[3] for example, was not implemented in Scotland. Further, bed closures have happened more slowly and the rushed 'top-down' functionalisation of mental healthcare enacted in England has been generally more measured north of the border. Indeed, it appears that only crisis resolution and home treatment teams have been widely adopted (reflecting in part the supporting evidence, for example Joy *et al*[4]), there being a more conservative adaptation of New Ways of Working.

Partially, this reflects a different politico-cultural backdrop in Scotland. There is, for example, a substantially smaller private and independent sector in mental healthcare here compared with England; funding, therefore, is not (usually) diverted in that direction. Furthermore, there is less preoccupation with risk to others, again limiting private secure facility expansion.

Additionally, New Ways of Working was in part a pragmatic solution to endemic problems with recruitment and retention into psychiatry. In Scotland, this has been less of an issue overall, with notable exceptions. Scottish workforce planning indicates that only child and adolescent mental health consultants are difficult to recruit in Scotland, and there has been a genuine uplift in consultant numbers in the past 5 years. Although there are important imminent universal challenges which could change the landscape (such as the diminishing number of junior doctors, and the evolving role of the psychiatrist as a medical doctor providing leadership within the multidisciplinary team), we contend that there is probably less dissatisfaction with current service configurations, less urgency to overhaul systems, and more opportunity to plan service change meaningfully on the basis of evidence and others' experience.

Thus, we have naturalistic experiment with separate and diverging systems of government-based healthcare in adjoining countries with similar underlying populations. This could be an ideal opportunity to examine optimal service configuration, as long as consensus on the best outcomes for patients could be achieved.

1 St John-Smith P, McQueen D, Michael A, Ikkos G, Denman C, Maier M, et al. The trouble with NHS psychiatry in England. *Psychiatr Bull* 2009; **33**: 219–25.

2 Dale J, Milner G. New Ways not working? Psychiatrists' attitudes. *Psychiatr Bull* 2009; **33**: 204–7.

3 Department of Health. *National Service Framework for Mental Health: Modern Standards and Service Models*. Department of Health, 1999.

4 Joy CB, Adams CE, Rice K. Crisis intervention for people with severe mental illnesses. *Cochrane Database of Systematic Review* 2006; **4**: CD001087.

***Mark Taylor** Consultant Psychiatrist, Intensive Home Treatment Team, Ballenden House, Edinburgh EH8 9HL, email: marktaylor2@nhs.net, **Premal Shah** Consultant Psychiatrist, Royal Edinburgh Hospital, Edinburgh

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Journal club syndrome: a newly described disorder of doctors in training

Journal clubs and case presentation meetings are an important part of 'in-house' training and an opportunity for all doctors to practise and develop presentation skills. There are ample

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suggestions for improving the quality of such clubs, but I could not find any that identified risks associated with this practice. I am happy to provide what in my knowledge is the first case-series report, based on anecdotal impressions, of such risks, with the knowledge and responsibility that it may generate a new field of research and debate or the definition of a journal club syndrome.

My experience suggests that the period preceding a journal club is directly associated with an increase of physical and mental health problems on presenting doctors, to an extent that makes it impossible to prepare for or deliver the presentation. Mental health problems include temporary cognitive deficits (mainly in the form of episodic memory loss that recovers with no intervention), manifested by a high number of doctors that have forgotten either that it was their day to present or to bring on the day the wrongly called memory sticks that carried all the data. In the latter case, further symptoms include the lack of alternative supporting methods and the common perception that stand-alone oral presentation cannot be delivered. Accidents, thefts and losses are also reported on a higher proportion in the pre-presentation period, to the point that health and safety regulation of journal clubs may become standard practice one day soon.

This evidence has been accumulated through many years of training and working in different areas, which suggests that the risk is not associated to specific grades of doctors, disciplines, environments, hospitals, trusts or geographical areas. As I continue to be surprised by the high quality of some presentations, mainly of very junior doctors, and challenged by their enthusiasm, I hope that this newly described syndrome does not present with associated apathy to others involved in the journal club.

Ignasi Agell Consultant Psychiatrist and Associate Medical Director, South Staffordshire and Shropshire Healthcare NHS Foundation Trust, Cherry Orchard House, 39 Hospital Street, Tamworth B79 7EE, email: ignasi.agell@sssft.nhs.uk

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The trouble with NHS psychiatrists

St John-Smith *et al*[1] provide a useful overview of the political imperatives which have shaped British psychiatry in the past 5 years, but as with other overviews[2] it is difficult for the reader to come away with any constructive message.

The authors rightly recognise the original New Ways of Working project as a practical response to a shortage of psychiatrists, but believe this has become a shorthand for cutting the number of medical staff and reducing the psychiatric orientation of the service. The national workforce figures suggest otherwise: between 1999 and 2007, the number of psychiatrists in England rose[3] by 46% and few can argue that recruitment is not vastly improved compared with 10 years ago.

The reality is that new services have grown even faster, with an estimated £2 billion of additional investment since 1999,[3] mainly in specialist teams. The recruitment of medical staff and the establishment of suitable training placements have lagged behind, as outlined by the Audit Commission finding that almost a third of crisis resolution teams had no dedicated consultant sessions.[4]

It is inevitable, and many would argue desirable, that non-medical staff will be involved in front-line assessment, as they are now in most other branches of medicine. The solution is not to decry 'proforma tools and guidelines', but to argue for these to be used by suitably trained and supervised staff working in teams with ready access to psychiatrists, as originally envisaged in New Ways of Working.[5] The College should lead on an overview of the medical staffing of specialist teams, and trusts and commissioners should be obliged to fund dedicated consultant sessions in order to meet their quality targets.

Although specialist teams provide some benefits, they have undoubtedly led to greater fragmentation of care and may not all survive beyond New Horizons.[3] Our battle should be to ensure that the additional money which came with these teams is not clawed back in times of greater austerity.

1 St John-Smith P, McQueen D, Michael A, Ikkos G, Denman C, Maier M, et al. The trouble with NHS psychiatry in England. *Psychiatr Bull* 2009; **33**: 219–25.

2 Craddock N, Antebi D, Attenburrow MJ, Bailey A, Carson A, Cowen P, et al. Wake-up call for British psychiatry. *Br J Psychiatry* 2008; **193**: 6–9.

3 Department of Health. *New Horizons: Towards a Shared Vision for Mental Health*. Department of Health, 2009.

4 National Audit Office. *Helping People through Mental Health Crisis: The Role of Crisis Resolution and Home Treatment Services*, 2007.

5 CSIP/NIMHE, CWP, Royal College of Psychiatrists. *New Ways of Working for Psychiatrists*. Department of Health, 2005.

Judy A. Harrison Consultant Psychiatrist and Clinical Director, Manchester Mental Health and Social Care Trust, Chorlton House, 70 Manchester Road, Chorlton, Manchester M81 9UN, email: judy.harrison@mhsc.nhs.uk

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Critical psychiatry seeks to avoid the polarisation engendered by anti-psychiatry

D. B. Double

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