Correspondence

Specialisation in psychiatry

DEAR SIRS

The letter by David Jolley[1] *Bulletin* (March 1988) makes a clear and strong case for the plight of old age psychiatry. Unfortunately, focusing on old age psychiatry obscures a number of wider and more fundamental issues.

Specialisation

In line with the aims of the Royal College of Psychiatrists in improving standards there is now the expectation that trainees will obtain wide experience in most of the psychiatric specialties and sub-specialties. Similarly, consultants in, for example, forensic psychiatry and psychiatry of the dependencies increasingly have a place in every district, not just a favoured few.

Within the College itself there are currently six Specialist Sections and three Specialist Groups. Consultants are increasingly distinguished by these 'special' labels. *British Medical Journal* consultant job advertisements now regularly demand 'specialist' skills. In my own survey of these jobs there was no difficulty in dividing them into at least 13 categories (ignoring 'general' and 'interest' posts).

Separate training and the job market

Manpower arguments before and after *Achieving a Balance* – and now with JPAC – rightly focus our attention on the mismatch between the kind of consultants we require and the training being delivered to senior registrars. It is disappointing to find that JPAC and NHS Regional Manpower Committees still subdivide psychiatry into the same old specialties: – (i) Mental Illness (Adult); (ii) Child & Adolescent Psychiatry; (iii) Forensic Psychiatry; (iv) Mental Handicap; and (v) Psychotherapy. Like Enid Blyton's *Famous Five* they belong to another era, a different context.

A look at the 'job market' highlights some of the reasons. All but one of the branches of psychiatry show a good proportion of jobs advertised in the *BMJ* (May 1986–87) occurring as a combination of adult general psychiatry with that branch (as a special interest or special responsibility). The range is from 18% for mental handicap to 100% for liaison psychiatry (see Table). The one exception is child & adolescent psychiatry.

TABLE

Combination (General and Interest) posts as a proportion of all the posts advertised in each Specialty/Subspecialty (Wholetime & General and Interest)

Old Age	38/70	56%
Mental Handicap	7/38	18%
Child & adolescent	0/47	0
Adolescent (only)	1/6	17%
Community	10/13	77%
Rehabilitation	17/19	89%
Dependencies	8/12	67%
Psychotherapy	4/11	36%
Forensic (not Special Hospital)	2/8	25%
Liaison	4/4	100%
Total	91/228	40%

British Medical Journal May 1986–87.

Such combination jobs amounted to 29% (91 of 313) of *all* NHS posts advertised, very similar to the 25% (79 of 313) for straightforward adult general psychiatry. (From Dr Jolley's figures the proportions are 21% and 25% respectively.)

Senior registrars from general psychiatry (rather than specialist) training schemes will thus fill specialist posts in some branches of psychiatry and the large majority of the combination posts in *all* branches of psychiatry. This increasing specialisation within general psychiatry makes the current separation into the 'Famous Five' specialties seem both arbitrary and elitist.

Management?

Dr Jolley's arguments for old age psychiatry are not new! They go back to at least 1984[2–5] with no immediate prospect of a solution.

At one level this would seem to be a failure of management. Vague directives have come from the centre (the College) to the first-line managers (the clinical tutors) and have had little impact. However, at the same time the 'company' is undergoing a re-organisation with the rise of a new breed of 'managing directors' heading their specialties.

A different analogy may make this clearer. The College and the clinical tutors may be represented as a mediaeval king and his ministers. The 'leaders' of the Specialist Sections (and Groups) would be the barons. When the monarchy is strong the strength of

the barons and their retainers works for the good of the country. When the monarchy is weak the barons tend to fight amongst themselves, the stronger ones taking power, land and resources from the weak.

The old age psychiatry barons (amongst others) are short of retainers. Their bid for status as a psychiatric specialty is like looking to the king for support. It may be their due but I wonder if the monarchy is strong enough to redress the imbalance of power?

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[2]WATTIS, J. P. *et al.* (1981) Psychogeriatrics: a national survey of a new branch of psychiatry. *British Medical Journal*, **282**, 1529–1533.

[3]WATTIS, J. P. & ARIE, R. (1984) Further developments in psychogeriatrics in Britain. *British Medical Journal*, **289**, 778.

[4]JOLLEY, D. (1985) (letter). *British Medical Journal*, **290**, 240.

[5]WATTIS, J. P. (1985) (letter). *British Medical Journal*, **291**, 1281.

Return of abused children to their parents

DEAR SIRS

I was greatly concerned by some of the points made by Dr Asen in the article describing the activities of the Marlborough Family Day Unit (*Bulletin*, March 1988, **12**, 88–90). He stated that Social Services frequently requested the unit to assess whether an abused child or children should be reunited or permanently separated from their family.

Whilst numerous risk factors have been identified in parents who abuse their children, much less work has been done to identify which parents will re-abuse their children once they have been returned to them. However, it is said that 10% of children die as a result of the abuse, 25% may become mentally retarded and 60% will be re-abused.[1] Therefore, the decision to return an abused child to his or her parents must never be taken lightly, but should this be a medical or psychiatric decision?

It has been estimated that less than 10% of abusing parents have evidence of formal psychiatric disorder.[2] So it is reasonable to ask whether psychiatrists have anything to offer the majority of these people who are not mentally ill?

The author told us that family systems psychotherapy is the treatment strategy used at the Marlborough Day Unit. However, further on in the article it became clear that some parents will have engaged in therapy with the knowledge that good behaviour at the unit could lead to a recommendation being made that their children should be returned to them. Surely this is not the basis on which psychotherapy should be undertaken. We were also told that "Social Services are required by us to put in concrete language ... what sort of changes they would need to see for them to be sufficiently convinced that the parents could have their children living with them". I would argue that we do not know the answer to this question, other than the obvious: not to abuse their children.

A day hospital staffed with psychiatric nurses, a visiting psychiatrist, and a social worker is hardly a 'normal' environment in which predictions can be made about how parents will behave in their own homes. Such an activity is nothing more than speculation.

Child abuse is an evocative subject and one that provokes a desire to help and protect. The decision to return an abused child to his or her parents is essentially a moral problem. I would argue that in the majority of cases psychiatrists do not have any expertise in this area and to offer a professional opinion would be unethical. It is up to the courts to make this decision and psychiatrists should not be seduced into making pseudoscientific predictions made in an artificial environment and based on little or no scientific evidence.

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References

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[2]PARKE, R. D. & COLLMER, C. W. (1975) Child abuse: an interdisciplinary analysis. In: *Review of Child Development Research*, Vol. 5. (ed. E. M. Hetherington). Chicago: University of Chicago Press.

Dr Asen replies

DEAR SIRS

I would like to make the following points in response to Dr Dunn's letter.

(1) When Dr Dunn wonders whether psychiatrists have anything to offer in child abuse cases, he entirely overlooks the possibility that physically abused children may also be suffering from related psychological disorders. Almost all of the abused children referred to the Marlborough