(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'.[2] If we forget this, then what indeed is the point of our being doctors?


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, Oyebode 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.

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.


**Mark Agius**, Academic Department of Psychiatry, University of Cambridge, UK. Email: ma393@cam.ac.uk

**doi: 10.1192/bjp.193.6.512a**

We welcome the debate initiated by Craddock *et al*[1] 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,[2] 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[3,4] (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, Oyebode 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.

2 Department of Health. *New Ways of Working for Psychiatrists. Enhancing Effective, Person Centered Services Through New Ways of Working in Multi-disciplinary and Multi-agency Contexts. Executive Summary of the Final Report 'but not the end of the story'*. Department of Health, 2005.

3 Care Services Improvement Partnership, Royal College of Psychiatrists and Social Care Institute for Excellence (SCIE) (2007) *A Common Purpose: Recovery in Future Mental Health Services*. Social Care Institute for Excellence, 2007.

4 Shepherd G, Boardman J, Slade M. *Making Recovery a Reality*. Sainsbury Centre for Mental Health, 2008.


**Jed Boardman**, South London and Maudsley Foundation NHS Trust, UK. Email: jedboard@atlas.co.uk; **Michele Hampson**, Queen's Medical Centre Nottingham, UK

**doi: 10.1192/bjp.193.6.513**

The interpretation in *The Times*[1] of Craddock *et al*[2] 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