Trainees' Forum

Beginning Psychiatry

GEOFF ADAMS, The Bethlem and Maudsley Hospitals and MARILYN A. COOK, Kings College Hospital, London SE5

Most people come into psychiatry from behind the white coat of more technologically orientated medicine. In psychiatry, with its slower pace and greater intimacy, it is seen as more important to consider the patients' feelings and there is time to do so. But here one's role is less clearly defined and assumptions carried over about the relation of the junior doctor to other staff may be inappropriate.

In medicine and surgery the patient's physical health is the responsibility of the houseman. His job is to carry out the consultant's instructions as to how the disease should be treated and liaison with the nursing staff forms a well-established system. The patient can be given firm guidance as to what he should do to maintain his health, and his personal affairs are not divulged except by invitation or particular need. But this relationship becomes different if the patient is dying and can give rise to much difficulty.[1]

Psychosis is viewed in terms of the medical model, and the positions of doctor and patient are similar to those in physical medicine. But patients with neuroses, personality disorders or moderate depression have some responsibility for their own mental health. The sharing of this responsibility is difficult but crucial, and is related to the balance between helping the patient and eliciting information from him. The systematic investigation of the responses produced by different types of questions has only recently begun.[2]

But we would like to stress two points. Firstly, no one except you and the patient really knows what happens when you take him for interview. You learn from your mistakes behind the closed door. Secondly, no one tells you how to be a psychiatrist. You are labelled, not unlike Scheff's patient,[3] although you have some preparation for the role, which he has not. Scheff's model is of a confused, anxious and ashamed patient, highly responsive to cues from others and guided by traditional stereotypes. Behind that door you act the role you have come to envisage, responding to cues from the patient.

It takes a long time to appreciate the freedom one has. Scientific medical training is not geared to the more artistic and philosophical demands of psychiatry even though communication skills are being taught increasingly. Malan[4] stresses the importance of a knowledge of people 'much of which may come not from any formal training or reading but simply from personal experience.' The position of a psychiatrist is fairly awesome but is attained through the ability to pass factual exams, not through personal qualities. Yet honesty, sensitivity and discretion are of paramount importance in psychiatry. For many trainees the first year of psychiatry coincides with a time when attitudes, philosophy and marital circumstances are evolving from vague notions into a shape for life and this process will inevitably be catalysed by questions of what is worthwhile in patients' lives. Some doctors like to distinguish themselves from patients and imply that they do not have their own psychodynamics. From bitter experience we believe this view may be associated with acting out! The idea of having an unconscious is unsettling, particularly if you work with people who feel able to see such a thing. Much of what constitutes professional skill in psychiatry might be seen simply as maturity outside it. One cannot be taught, except indirectly, the concept of normality or qualities of empathy and open-mindedness.

Another aspect of beginning psychiatry to be considered relates to the practicalities of the system in which the SHO works. In many ways his position is the most vulnerable on the ward. Nurses work in shifts and are criticized, if at all, behind the scenes. Social workers, psychologists and occupational therapists enjoy a degree of independence, but the SHO has his work held up for scrutiny at each ward round in front of the other staff. He has no one of equivalent status with whom to share responsibility. Since the art of psychiatry blends into general interpersonal style the line between professional criticism and personal insult is a fine one. Some consultants are tactful and skilled in observing this but others stray across it apparently without realizing. Central issues in the working relationship could be discussed more openly such as how much control the SHO is expected to take at ward rounds, how much detail to include in presentations and how keenly to defend himself in debate.

More subtly, but perhaps more importantly, the post of SHO suffers (although the individual gains in other respects) from having a new incumbent every six months. The consultant and other ward staff develop interests and gradually shape their job but no one holds the SHO post in shape except from the outside. This means that, where there are conflicting interests, the succession of SHOs is at a disadvantage, and a number of trivial issues may summate to make the job unreasonably difficult. When the ward is busy, the sum of demands on him may be more than the individuals passing work on to him realize. What one needs to learn—to be firm and cope with the pressures—is more of a personal asset than a professional skill one deliberately sets out to acquire.

The first year of psychiatry is a challenge. One has to become acquainted with a new field of medicine and to understand how its orientation differs and how this affects the doctor's role. Psychiatry is about life in a broader sense

than the rest of medicine and it can be difficult to distinguish ideas of how one should approach it from ideas of how one should approach life. The main thing is not to be crushed by all the things wrong with the patients and the system but to be interested in the positive aspects of each and work out what to do with them.

REFERENCES

[1]ADAMS G. P., & COOK, M. A. (1981) The houseman and the dying patient. *Journal of Medical Ethics*, **7**,142–5.

[2]RUTTER, M., & COX, A. (1981) Psychiatric interviewing techniques: I. Methods and measures. *British Journal of Psychiatry*, **138**, 273–82.

[3]SCHEFF, T. (1968) The role of the mentally ill and the dynamics of mental disorder. In *Studies in the Sociology of Deviance* (eds S. P. Spitzer and N. K. Denzin). New York: McGraw Hill.

[4]MALAN, D. H. (1979) *Individual Psychotherapy and the Science of Psychodynamics*. London: Butterworths.

Reviews

Report on the Future of the Special Hospitals. Royal College of Psychiatrists. 1983. Pp 43. £1.

The title of the Report reflects the Special Committee of Council's most important term of reference, '... (to) make recommendations for the future'. But the future looks bleak. After years of campaigning in other quarters for the repeal of the Official Secrets Acts, the College decides merely that they should not apply to staff in the Special Hospitals. As far as future management is concerned, the Report takes the line proposed by the 1968 Estimates Committee, the 1973 Elliot Report on Rampton Hospital, and the 1975 Hospital Advisory Service report on Broadmoor Hospital: all recommended local rather than central DHSS management. But the Committee's pusillanimity is shown by their recommendation that local Management Committees including representatives of NHS psychiatric services, district and regional health authorities, university departments and the local community, should not be imposed on hospitals with well functioning Management Teams, comprising medical director, head of nursing, and hospital administrator. Management Committees should only be forced on unhealthy (sic) hospitals with demonstrable disharmony and widespread lack of confidence (if Yorkshire Television doesn't get there first). Elsewhere a curious comment provides what the reader is to take for a reason: different areas of interest and specialization (between Special Hospitals) suggest that a common management structure is inappropriate. How does the rest of the health service manage?

For a Committee born of both the problems surrounding the integration of regional secure units with mainstream psychiatry and the shadow of the Rampton Hospital inquiry, the Report is both blinkered and self-interested. Consultants should have fewer cases, more money and better links with the rest of psychiatry. Financial recognition should be made for the fact that Special Hospital consultants cannot engage in private practice—although they knew this when they applied for their appointments—and a special responsibility allowance should be paid in addition to the present Special Hospital lead.

The Report is also disappointing in that the Committee reiterates the common fallacy that mental hospitals have lost their expertise in dealing with difficult patients when all that has gone is the exercise of patronizing repression and the staff of some hospitals are at last learning how to manage difficult and assaultative patients in a humane manner. In addition members of Council's Committee failed to address themselves to the question of how many places should be provided in Special Hospitals. In 1968 there were 2,500 and 1,800 in 1981. But how many places do we need? Why not 1,000? Why not close one Special Hospital? The other area in which expectations are not met is the blind support which the Committee gives to the DHSS in its negotiating with the General Nursing Council which clearly has doubts over the Special Hospitals' suitability for nurse training. There is no debate of these issues, no dialectic, but dogma to allay fears of more recruitment problems if nurse training recognition is withdrawn.

In urging psychiatrists to seek the opinion of a Special Hospital consultant beforehand the Report contradicts DHSS advice that all Special Hospital referrals should be channelled through the Department. And do we not deserve something more than the tautology that milieu therapy is believed to have beneficial effects on retraining and resocialization of patients exhibiting antisocial behaviour? And was the Report not the place to nudge the delicate balance of the interests of security versus treatment in favour of the latter? We have much to learn from penal incapacitation studies which show that a very large increase in the length of imprisonment results in only a very small decrease in the amount of crime and, conversely, that a large reduction in the amount of imprisonment would result in only a small increase in the amount of crime.

PAUL BOWDEN

Maudsley Hospital
London SE5