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From the Editor's desk

By Peter Tyrer

Keeping the fire burning

Psychiatrists spend much of their time in assessing desires and motives and so this often extends to their colleagues as well as their patients. In my own career I have detected three phases in their progression: the first, of enthusiasm and optimism; the second, of freewheeling or coasting; and the third, of disillusion and avoidance. These phases are not universal, but I seem to see them more frequently than I used to, and it troubles me, especially the insidious change in practice towards the sanitisation of contact with patients that accompanies career progression in so many countries. Although the work of this *Journal* and others advances knowledge, technology and, we trust, outcomes of mental illness, the key element of good care is personal interest, the genuine concern to get to the heart of an individual problem and get it sorted. Once we lose that, we cannot make up for it fully despite the acquisition of greater knowledge and an abundance of guidelines. Several of the papers in this issue add substance to this subject, particularly that by Johnson *et al* (pp. 239–246) on the morale of staff working in psychiatric services. These authors find that the real front-line workers in psychiatry, who are usually the most junior, working in community mental health teams and intensive care wards in hospital, have the greatest levels of emotional stress, so seeming to support my impression that to survive for a long period in psychiatry it is better to escape the tribulations of contact with difficult patients and go elsewhere. Although this paper comes from the UK, the same findings have been shown elsewhere in high-income countries[1] and this must give us pause, especially as we are attempting to export these models of care elsewhere.

What can we do about this? Burns (pp. 178–179) is quite frank in admitting the difficulties in promoting a remedy. What is clear is that reorganisation of services or, more accurately, DICTREP (deliberately instigated chaos to relieve economic pressures), is not a way forward as it only accentuates lack of autonomy, especially for younger practitioners. We also do not need to be channelled into the burgeoning bureaucracy of what masquerades as 'performance'[2] but which is more frequently a frantic attempt to airbrush artificial virtue into everything we have done, quite irrespective of its real value. Burns rightly wants to stop the 'endless change and meddling' that has dogged the mainstream psychiatric services in recent years. It is very difficult to practise psychiatry in its core service for those with severe mental illness, a place which I often call the last-chance saloon, where all go to when other options have been tried and failed. Here the twin barbs of understood, but often highly personal, abuse from disturbed patients,[3] and the ever-present monitoring of managers and media, are always ready to launch into damning criticism as soon as something goes wrong. We in our journals are not free of blame. We publish much research pointing to the need for practitioners to have greater awareness of risk[4] and to be more aware of preventive strategies,[5,6] and, while we mean well, failure to observe these may be used against overwhelmed practitioners already at the end of their tether. The emphasis on preventing suicide, although important in all, whether high or low risk (Pitman & Caine, pp. 175–177; Gunnell *et al*, pp. 233–238), also takes its toll, although thankfully we have now stopped having high-profile suicide enquiries which only parroted meaningless recommendations about 'better communication' as a solution. We need to acknowledge that in the last chance saloon we can still show humanity and care without too much coercion,[7] where recovery may be limited but not hopeless (Oorschot *et al*, pp. 215–220), and where we can still collaborate with the most difficult of our charges.[8–10] On many occasions in the past 30 years when I have gone out of my way to do something for patients that has not been part of what our American colleagues call 'my schedule', I have had colleagues stare at me and one or two say what I think many of them have felt – 'you sucker'. A charter for suckers is now what we need to give the right and proper acknowledgment for unsung goodwill and effort.[11]

Gold medal for the National Health Service

I write this piece during the 2012 Olympic Games in London. Those who watched the opening ceremony will have realised that one of the first gold medals of the Games was given to the National Health Service (NHS), one of the great assets of the UK that has still not been exported in full to any other country. On 5 July 1948, when the NHS began its work, mental health was low on its agenda. Yet over half of all hospital beds in the country were those for people with mental illness, although, but for Aneurin Bevan, the real founder of the NHS, who decided that mental health facilities should be part of the NHS and not under local authority control,[12] things might well have turned out very differently. Bevan's famous principle was 'no society can legitimately call itself civilised if a sick person is denied medical aid because of lack of means'. Whatever our political views or economic woes, this cannot be a sentiment denied.

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